draft

Improving the Health Status of Malagasy

through

Social Marketing

of

STI/HIV/AIDS Prevention Products
Franchised Reproductive Health Services for Adolescents
Hormonal Contraceptives
and
Maternal and Child Health Products

PSI
MADAGASCAR

AIDSMark Workplan

October 1, 2003 – September 29, 2007

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I. EXECUTIVE SUMMARY

Population Services International (PSI) requests $9,978,354 to continue and expand its social marketing and behavior change program in Madagascar over a four-year period. The overall aim of this program is to contribute to the improvement of the health status of Malagasy.

PSI's social marketing project is designed to improve sexual health among high risk groups by increasing self-risk perception and effective risk management while ensuring widespread access to affordable STI/HIV/AIDS prevention products throughout the country. Ultimately, PSI will encourage healthier behaviors whereby messages promote delay of sexual debut, partner reduction, and, where appropriate, consistent and correct condom use. In order to address maternal and child morbidity and mortality, the project will use commercial strategies to increase informed demand for family planning, increase the use of maternal and child health products and improve the quality of reproductive health services through private sector partners.

Proposed funding will contribute to the continuation of these existing program components; estimated to generate a total of **9,654,681 Person Years of Protection**:

Product	**Launch Date**	**Combined target distribution for October 2003 to September 2007**	**Estimated person years of protection (PYP) generated**	**Comments**
Protector Plus male condoms	1996	42,669,270 condoms	355,577 Couple Years of Protection (CYPs)	1 CYP = 120 condoms sold
Pilplan oral contraceptives	1998	5,105,100 cycles of oral contraceptives	340,340 CYPs	1 CYP = 15 cycles of oral contraceptives
Confiance injectable contraceptives	1998	1,837,836 3-month injectable contraceptives	459,459 CYPs	1 CYP = 4 3-month injectable contraceptives
Sûr 'Eau water purification solution	2000	1,572,165 bottles	1,572,165 Person Years of Treated Water (PYTW)	1 PYTW = 1 500 mL bottle
SuperMoustiquaire long-lasting insecticide-treated mosquito nets (LLITN)	2001	2,360,500 LLITNs	6,626,151 Person Years of Malaria Protection (PYMP)	1 PYMP = 0.35624 LLITNs sold
TOP Réseau franchised network of adolescent reproductive health services	2001, established as a pilot project in Tamatave	101,920 clients served in all 5 TOP Réseau sites	PYP conversion factor has not yet been established for health services.	With AIDSMark support, the network will be expanded to 10 clinics in the northern port city of Diego in 2004.
Cura7 pre-packaged STI treatment kits for gonorrhea and chlamydia,	2002	649,740 STI treatment kits	38,220 CYPs	1 CYP = 17 kits sold
Genicure pre-packaged STI treatment kits for ulcerative STIs, namely syphilis and chancroid	To be launched Q1 2004	255,255 STI treatment kits	15,015 CYPs	1 CYP = 17 kits sold
Palustop pre-packaged malaria treatment for children under five,	To be launched Q4, 2003	1,610,400 malaria treatment kits	247,754 Child Years of Malaria Treatment (CYMT)	1 CYMT = 6.5 kits sold; Additional age groups, for older children and adults, may be added.

Generic behavior change campaigns, including mobile video unit, mass media and interpersonal community-based activities, will be an integral part of each of the above components.

The following workplan summarizes the proposed target results, activities, and monitoring and evaluation plan for the Madagascar AIDSMark Project (USAID Agreement Number HRN-A-00-97-00021-00) in the period October 1, 2003 – September 29, 2007.

II. SITUATION ANALYSIS

STI/HIV/AIDS in Madagascar

Madagascar is one of the last remaining countries in Sub-Saharan Africa in the nascent stage of an AIDS epidemic. HIV seroprevalence per 100,000 Malagasy adults rose from 20 in 1989 to 70 in 1995 and to 300 in 2001[1].

Seroprevalence data collected this year demonstrate that HIV prevalence now actually exceeds 1%. The data, collected in Madagascar's six provinces, show a range from 0.3 to 1.51% in HIV prevalence. [2]In the absence of widespread effective STI/HIV/AIDS prevention programming HIV prevalence is projected to soar to as high as 15% of the adult population by the year 2015, leading to severe demographic, social, and economic impacts.[3] Following the political and economic crisis in Madagascar in 2002, there are growing fears that HIV/AIDS has an opportunity to take an even stronger hold on the island. The UNDP and UNAIDS have recently reported (July 2002) that the number of commercial sex workers (CSWs) in Antananarivo have increased by 50% in recent months due to the new economic hardships. These new and increasingly young sex workers are the most vulnerable and least knowledgeable on methods of protection against HIV/AIDS.

The Ministry of Health (MOH) estimates that across the island STIs are the sixth most common cause for seeking health care.[4] With scarce national data on STI prevalence, infertility data can act as an indirect measurement of the magnitude of the STI problem in a population, as untreated gonorrhea and chlamydia may damage fallopian tubes and cause infertility. In a study of women in 27 African nations, Madagascar was found to have infertility rates within the highest quartile.[5]

Evidence indicates that the presence of an STI may increase the risk of transmission of HIV from person to person by two to nine times.[6] Experts warn that with high rates of STIs and the presence of a variety of behavioral risk factors (e.g., multiple sex partners and low levels of condom use), Madagascar is poised at the brink of an HIV/AIDS crisis. The situation in Madagascar is therefore at a critical stage and there is a rare window of opportunity in which to prevent the large-scale epidemic that is currently ravaging sub-Saharan Africa. The scope and intensity of health interventions will determine the course of the epidemic.

Certain risk groups in Madagascar have extremely high rates of STIs. Research in Antananarivo and Tamatave reveals that 39% of women in general, 62% of occasional sex traders, and 64% of CSWs presenting at health clinics with genital discharge syndrome have at least one active STI.[7] This rate is one of the highest in Africa and the world. Among this

[1] Ravaoarimalala C et al, Politique d'intervention pour maintenir la basse prevalence de l'infection par le VIH;
[2] Etude Combinée des Séro-prévalences de l'infection à VIH et de la Syphilis chez les femmes enceintes à Madagascar, Ministère de la Santé, Juin 2003.
[3] Ravaoarimalala C et al, Politique d'intervention pour maintenir la basse prevalence de l'infection par le VIH; UNAIDS Epidemiological Fact Sheet 2002
[4] Behets F, et al. "Sexually transmitted infections and associated socio-demographic and behavioural factors in women seeking primary care suggest Madagascar's vulnerability to rapid HIV spread." *Trop Med & Int Health*. March 2001, 6(3):203.
[5] Ibid, pp. 202-3.
[6] Lande R. "Controlling Sexually Transmitted Diseases."
[7] Ibid, p. 205.

sample, 25% of the CSWs had syphilis and 35% had cervical infection caused by either gonorrhea or chlamydia. The latest seroprevalence rates for syphilis from the Ministry of Health show that 8.2% of pregnant women at health care centers were infected. The highest rates were seen in Tamatave (16.8%), Diego (8.9%), and Tulear (8.7%).[8]

In addition to CSWs and their clients, youth are an important focus for STI prevention efforts in Madagascar. It is among people in their teens and twenties that most new STI and HIV infections occur. A study conducted through the Institut Pasteur in a rural community in Diego province in 2002 found STI rates three to four times higher among the 15-24 age group than among 25-49 for gonorrhea and chlamydia[9]. Lack of knowledge regarding prevention of STIs and HIV and low risk perception have led to chronically low levels of condom use. Research suggests that less than a third of adolescents know that condoms prevent HIV transmission.[10] According to data from the 1997 DHS, among 15-19 year old-females who know about AIDS and who have already had sex, only 7% had ever used a condom.[11] This low condom utilization rate among young women is disturbing, as the latest HIV sero-prevalence study shows that, among pregnant women, those less than 20 years of age have a much higher-than-average HIV prevalence rate with women between 15 and 19 years of age at 1.35% and those and less than 15 years of age at 1.64%. [12]

Family Planning in Madagascar

Madagascar's population is growing at a rate of approximately 3% per year. On average, women in Madagascar give birth to six children, a statistic that has remained virtually unchanged since 1992, with 57% of women giving birth by age 20.[13] Reports indicate that illegal abortion is extremely high and rising among young women. Almost one-third of all babies are born less than 24 months after their next oldest sibling, contributing to maternal morbidity and mortality rates that are among the highest in the world.[14]

There is a fundamental lack of knowledge regarding reproductive health, leading to low contraceptive use rates in Madagascar. Recognition of the utility of family planning is also very low. Only 56% women surveyed in 2001 have adequate knowledge of family planning methods and only 46% recognized the usefulness of using contraceptives.[15] As a result of this, the use of a family planning method to prevent pregnancy is not commonly practiced in Madagascar. The table below illustrates that only 21% of women in the capital city Antananarivo adopt a modern family planning method to prevent pregnancy and the rates are much lower in peri-urban and rural areas.

[8] Etude Combinée des Séro-prévalences de l'infection à VIH et de la Syphilis chez les femmes enceintes à Madagascar, Ministère de la Santé, Juin 2003.
[9] « Infections Sexuellement Transmissibles dans un Foyer Rural à Madagascar » Peter Leutscher et al, IPM, 2002
[10] MICS 2000, p. 162.
[11] Ibid, p. 178.
[12] Ibid.
[13] International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.
[14] Ibid, p. 41
[15] EPM 2002 Household Study

Rate of utilization of family planning methods:

	Modern methods	Traditional methods	No method
Capital	20.5	7.5	72.0
Big urban centers	14.3	7.0	78.7
Secondary urban centers	15.4	6.4	78.2
Rural areas	9.8	4.8	85.4
All of Madagascar	**11.5**	**5.4**	**83.1**

Source: INSTAT/EPM2002

Around 50% of users of modern methods use injectable contraception, while around 28% use oral contraceptives. Only 14% reported using condoms as a method of contraception. Contraceptive Prevalence rates are highest in the provinces of Antananarivo, Diego, and Tamatave, and lowest in the provinces of Tulear and Majunga.[16]

The same study also revealed that among sexually active women, apart from wanting a child, lack of knowledge of method (11.3%), fear of side effects (4.4%) and partner opposition (3.3%), are the main reasons for not using a contraceptive method.

Reasons for non-use	Antana-narivo	Fianar-antsoa	Toam-asina	Mahaj-anga	Toliara	Antsir-anana	Total
Don't know method	7.2	14.7	14.3	12.6	10.0	9.7	11.3
Don't know source	0.5	3.1	0.5	2.5	1.3	3.5	1.7
Fear of side-effects	5.6	3.8	3.4	3.5	3.0	8.3	4.4
Interviewee opposes	3.7	3.0	2.2	0.9	1.4	2.1	2.5
Partner opposes	3.7	3.6	2.0	3.5	2.2	4.5	3.3

Source: INSTAT/ EPM2002

There remains a tremendous unmet need in Madagascar for family planning measures. A quarter of all women surveyed in 1997 who have never used contraception say they want to start within the next 12 months, while an additional 10% say they want to start after one year.[17] For those already in relationships, the figures jump to 32% and 12%, respectively.[18] The national INSTAT study (1999) showed that 78% of 15-19 year olds and 59% of 20-24 year olds want to wait at least 2 years before having another child.[19] Awareness of uses of family planning and knowledge of different methods available are important developmental areas.

Maternal and Child Health in Madagascar

Although easily preventable, malaria and diarrheal diseases are among the leading causes of morbidity and mortality in Madagascar.

[16] MICS 2000, p. 87.
[17] Enquête Démographique et de Santé, 1997, p. 62.
[18] Ibid, p. 62.
[19] INSTAT, Enquête Prioritaire, 1999, p. 59.

Malaria

Malaria is the leading cause of mortality and morbidity in Madagascar, with a disproportionate impact on pregnant women and children. In 2000, 1,426,366 cases were reported at public health centers and district hospitals. Malaria prevalence is estimated at 16 percent.[20]

Children under five years of age are the most vulnerable because they have not yet developed protective levels of immunity. Malaria is the second highest cause of morbidity among children under five years in Madagascar and 22 % of infant deaths in 1999 in hospitals were due to malaria[21].

Malaria in pregnancy is associated with very high risk of both maternal and peri-natal anemia. Babies born to such mothers are at high risk of low birth weight with a four-fold increase in risk of mortality. Those living in rural areas and poorer housing conditions with limited barriers between the mosquito and themselves are at continual high risk.

Malaria is considered a problem by the Malagasy, but its gravity is still underestimated. For example, 99% of respondents in a PSI/KAP study conducted in 2001 had heard of malaria. However, only 70% of respondents knew that malaria can be fatal.

Although it is generally known that malaria can be transmitted by mosquitoes no one (0%) could cite mosquito bites as the ONLY mode of transmission (PSI/KAP 2001). While 59% of respondents in the 2001 PSI KAP study, conducted in the district of Tamatave, cited mosquito bites as a mode of transmission for malaria respondents also cited: working in the sun (24%), change in climate (32%), getting wet from the rain (22%), and fatigue (17%).

In the 2001 PSI KAP survey, 80% of respondents identified children less than 5 years as among the most at-risk groups, however only 16% identified pregnant women as at risk.

Malaria prevention: Results from four trials in Africa showed that using treated nets reduced child deaths by between 17% and 33%.[22] Insecticide-treated nets were not commercially available in Madagascar until the launch of *SuperMoustiquaire* in September 2001.

In Tamatave II, 52% say that a net is the best way to protect themselves from malaria. And 70% of respondents at least own an untreated regular net. (PSI/KAP 2001). However, most people do not know what a treated net is. In Tamatave, only 20% of respondents have ever heard of a treated mosquito net and almost no one (.5%) reports using a treated net.

Malaria treatment: Information to date from the Réseau d'Etude de la Résistance du Paludisme (established by the Ministry of Health and the Institut Pasteur de Madagascar(IPM)) indicates that chloroquine resistance is still low in Madagascar, making the drug a highly effective treatment for malaria.[23] National policy allows for chloroquine to

[20] Annual statistics from the Madagascar MOH, 2000, pp. 108-119
[21] U.S. bureau of the Census, Intl Data Base, projection 2002
[22] Insecticide Treated Net Projects: A Handbook for Managers; Chavasse, Desmond et al., p. 5.
[23] Randrianarivelojosia M, Sahondra-Harisoa JL, Raharimalala LA, Raveloson A, Mauclere P, Ariey F. Evaluation in vitro de la sensibilité de Plasmodium falciparum à la chloroquine dans la région de l'Océan Indien dans le cadre du réseau d'étude de la résistance (RER). Cahiers Santé 2003 ; 13 : 95-100

be sold without prescription; however, proper dosing remains a problem. A mystery client survey carried out for PSI revealed extremely poor knowledge among pharmacists and even health care providers regarding correct chloroquine dosage, particularly for children.

Correct dosage is complicated by the fact that the public sector distributes a 150mg tablet while the private sector distributes 100mg tablets, creating confusion regarding given dosages. Widespread noncompliance with the full drug regimen and improper dosing are major factors that can eventually contribute to the development of drug resistance in the country.

Diarrheal Diseases

Diarrheal diseases are among the leading causes of morbidity and mortality in children under five in Madagascar. A 2000 Ministry of Health survey revealed that diarrheal disease accounted for 25% of children brought to district hospitals and 24% of child deaths there.

A 2000 national survey indicates that 13% of children under five have had diarrhea during the preceding two weeks, and infants six to eleven months old are most affected, at 25%.[24] The highest prevalence of diarrhea was found in the province of Tulear, and the lowest prevalence in Antananarivo.[25] The study also found an inverse correlation between a mother's level of education and the occurrence of diarrhea in her children.[26]

In Madagascar, some 75 % of people – up to 88% in rural areas – lack access to potable water, putting them at significant risk of diarrheal diseases, including cholera, according to the Multiple Indicator Cluster Study (MICS), conducted by Madagascar's Institut National de la Statistique (INSTAT) in 2000. Nationally, 59 % have access to some form of infrastructure for excreta removal, however this is most often a simple shallow hole.

Except in periods of heavy rains or after cyclones, water treatment is often perceived as non-essential. Mothers are convinced of the cleanliness of water from the local water and energy company, JIRAMA, in urban areas and from "natural" sources in rural areas. Additionally, mothers are often unaware of the link between unclean water and disease.[27]

Government of Madagascar and Ministry of Health Response and Priorities

The Comité National de Lutte Contre le VIH/SIDA (CNLS) is responsible for national HIV/AIDS and STI prevention and control and reports directly to the President of the Republic of Madagascar. This body was formed in 2002, in order to develop a multi-sectoral response to the fight against STI/HIV/AIDS, and is made up of representatives of key ministries, civil society organizations and NGOs. It works in three main domains:

1) strategic planning,
2) resource mobilization, and
3) improving the institutional environment.

[24] MICS 2000, p. 111.
[25] Ibid.
[26] Ibid.
[27] PSI Etude Faisabilite, SRO, 2001

The CNLS has spent its first year of existence prioritizing the finalization of the national HIV/AIDS strategic (for the period 2002-2006) by holding a number of workshops with a a diverse set of stakeholders, including PSI. With the national HIV prevalence rate officially at just over one percent, but with extremely high STI rates, the national strategic plan places great emphasis on STI prevention and treatment as a principal way of preventing the transmission of HIV. The Government has therefore been engaged in numerous activities, including establishing STI diagnosis and treatment protocols and distribution of STI treatment drugs through the public sector. The WHO sponsored syndromic approach to STI management has been used in Madagascar since 1997, although not on a widespread basis. The current quality of STI services offered within the public sector is considered poor (as measured by well-defined service quality indicators[28]). This AIDSMark project will play an important role in the overall national HIV/AIDS control strategy by reducing the age of sexual debut, reducing the number of partners, as well as increasing access to and use of condoms and high-quality STI treatment and prevention services.

The CNLS has focused its strategy on 20 geographic zones at highest risk of HIV infection, namely: Morondava, Sainte Marie, Tamatave, Tulear, Ilakaka, Diego, Nosy Be, Fort Dauphin, Tsiroanomandidy, Mananjary, Antsirabe, Antsohihy, Majunga, Fianarantsoa, Antananarivo, Sambava, Manakara, Moramanga, Fenerive Est, Miandrivazo.

The CNLS and MOH have defined HIV/AIDS prevention related objectives in the *Plan Strategique National de Lutte Contre Le VIH/SIDA* (December 2002). The principal objectives being to maintain the prevalence of HIV/AIDS at or below 1% and to ensure the well-being of persons living with HIV through their psychosocial and medical case management, the 5 main strategic directions of the national plan are as follows:

Strategic direction 1: Creating a working environment in which a multi-sectoral HIV/AIDS prevention strategy can flourish.
Strategic direction 2: Improving access to information and reinforcing prevention methods
Strategic direction 3: Ensuring service quality
Strategic direction 4: Reinforcing of HIV-related intervention monitoring and evaluation systems
Strategic direction 5: Developing an international, collaborative approach to the fight against HIV/AIDS

The PSI/Madagascar AIDSMark Project's planned interventions respond directly to the following *Plan Strategique National de Lutte Contre Le VIH/SIDA* objectives:

1. Improve access to information and HIV/AIDS primary prevention methods

   Expected result: At least 90% of the population will have regular access to information and educational messages through radio and other local channels by December 2006.

[28] IP (Indicateurs de Prevention) measures were developed by the WHO as indicators to measure the quality of HIV prevention activities, and IP6 (clinical STI case management) and IP7 (preventative counseling) are two that relate specifically to STIs.

2. Promote low-risk behavior related to preventing HIV/AIDS

   Expected result: Increase in the proportion of the population informed about the risk of HIV transmission associated with certain practices

   - Percentage of young adults who know at least two methods of HIV prevention
   - Percentage of single youth aged 15 to 24 years who have used a condom during their last sex act.

   Expected result : Increase in the proportion of the population engaged in healthy, low-risk behavior

   - Percentage of young adults who used condoms during their last sex act in the last 12 months
   - Percentage of people who systematically used condoms during their last sex act with a casual partner or sex worker.

3. Reduce STI prevalence

   Expected result: Improved quality of STI care

   - Percentage of STI patients at selected health centers receiving correct diagnosis and adequate treatment
   - Percentage of health providers having received a training in the syndromic approach to STI case management during the last 24 months

   Expected result: Increase in condom use by December 2006

   - Percentage of persons reporting male or female condom use during sex with an occasional partner over the last 12 months
   - Number of condoms sold per province per year

Similarly, the MOH has clearly defined Madagascar's national health objectives and strategies in its most recent policy guidelines publication, *Politique Nationale en Santé de la Reproduction 2000-2003*. The policy/strategy document for the period covered by this project is covered by this plan. The planned activities and interventions of the Madagascar AIDSMark Project will respond directly to the following Ministerial priorities:

1. Reduce the STI incidence rate by 30% among youth (15 – 24 years old; base incidence not cited).
2. Reduce the prevalence among the general population of curable STIs from 450 to 375 per 100,000 in order to limit the propagation of HIV/AIDS.
3. Reduce the maternal mortality rate from 490 to 285/100,000 live births.
4. Increase the overall contraceptive rate from 11% to 15% among women of reproductive age in union.
5. Reduce teenage pregnancy from 19% to 13% among adolescents 15 – 19 years old.

Other MOH priorities described in the *Politique Nationale de Santé 1996 - 2000* include reduction in morbidity from diarrhea by 50%, and reduction in the incidence of diarrhea among infants less than 5 years by 25% (base indices not cited).[29] The activities planned in the Madagascar AIDSMark Project also fall within the following large MOH priorities:

1. Decentralize the National Health System
2. Develop the private sector
3. Increase the number and quality of human resources involved in health
4. Encourage community participation
5. Promote maternal and child health and reproductive health.[30]

USAID/Madagascar's Strategy

USAID Madagascar has recently completed its five year strategic plan for FY 2003-2008.

The integrated strategic framework has as its goal the sustainable and inclusive economic development of Madagascar, with four strategic pillars to achieve this.

PSI Madagascar's program will fall within two of these strategic pillars:

- Use of selected health services and products increased and practices improved;
- Critical private markets expanded

USAID's strategic focus remains national in scope and covers the STI/HIV/AIDS prevention, reproductive health, and maternal and child health components of our interventions. The strategic framework includes a number of regionally focused initiatives in high risk areas. These include the 20 HIV/AIDS high risk zones identified by the CNLS, including the region covered by the "Global Alliance" between USAID and QMM, a mining company in Fort Dauphin (Tulear province).

PSI/Madagascar's Social Marketing Program

PSI is an international private non-profit organization dedicated to improving the health of low-income people through social marketing. With over 30 years experience and programs in more than 60 countries, PSI is the largest social marketing organization in the world. Social marketing makes use of existing commercial channels to deliver needed health products at a price affordable to low-income population, and develops and implements accompanying behavior change communications strategies.

Madagascar's USAID-supported social marketing products, (condoms, oral contraceptives, and injectable contraceptives) were introduced under "Social Marketing for Change" (SOMARC), managed by the Futures Group between 1996 and 1998. The projects were assumed by Commercial Marketing Strategies (CMS), managed by PSI, between 1998 and 2001, and fully supported by AIDSMark since May 2001. The current reproductive health brands promoted by PSI are *Protector Plus* condoms, *Pilplan* oral contraceptives (*Duofem*),

[29] Politique Nationale de Santé 1996-2000, pp. 23-24, 52-53, 58-59.
[30] Ibid, pp. 24-25

Confiance 3-month injectable contraceptives (*Depo Provera*), *Cura7* pre-packaged STI treatment kits, and *Top Reseau*, franchised adolescent reproductive health clinics. Other socially marketed brands are PSI's 0.4% sodium hypochlorite solution, *Sûr'Eau*, and *SuperMoustiquaire*, long-lasting insecticide treated nets. Currently in development are *PaluStop*, pre-packaged malaria treatment for children under 5 and *GeniCure*, pre-packaged STI treatment kits for genital ulcers.

During the period January through August 2003, PSI/Madagascar generated 168,948 couple-years of protection (CYPs) via the sales of condoms, oral contraceptives, and injectable contraceptives. This represented 115% of the target for that period. The achievements of the project are detailed in Appendix A.

A large part of PSI/Madagascar's success, beyond its behavior change communication campaigns and its strong distribution systems, has been achieved through its complementary training programs for NGOs, private doctors, and other private sector enterprises. PSI is the sole provider of continuing professional education in reproductive health to the private sector. The programs include training in STIs and the syndromic management approach, training in family planning and, more detailed training in prevention and treatment of malaria and diarrheal diseases.

Partnerships

In the pursuit of workplan objectives, the program has developed and maintains important and lasting partnerships with several private sector companies and cooperating agencies in Madagascar.

Association des Organisations Non Gouvernementales (ASSONG): The 10 largest and most economically viable members of ASSONG, an association of NGOs and private businesses that provide clinical reproductive health services, have been successfully reoriented towards social marketed contraceptives and away from receiving free contraceptive products with a view to securing the long-term availability of contraceptives in Madagascar. PSI has sold a total of 164,131 oral contraceptive cycles and 138,840 injectable contraceptive doses to ASSONG members as of September 2003.

SALAMA: SALAMA is the national tendering bureau that purchases medications using international quality tenders and sells them into the public and not-for-profit sectors at a minimal mark-up. SALAMA currently sells social marketed contraceptives into not-for-profit channels (including ASSONG members), and has recently negotiated with PSI and the World Bank to purchase 500,000 *Cura7* STI Kits for distribution through the public sector.

FARMAD: FARMAD is the largest private sector pharmaceutical distributor in Madagascar, and manages the packaging and distribution of all PSI pharmaceutical products, including *Pilplan, Confiance* and *Cura7*. By law in Madagascar, only a certified distributor can take on this task, and PSI and FARMAD have worked well together to ensure the products' availability in private sector pharmaceutical wholesalers throughout the country since 1998. PSI is in the process of negotiating a multi-product contract with FARMAD for distribution in the pharmaceutical sector of *Protector Plus*, *Super Moustiquaire*, *PaluStop*, *Pilplan, Confiance*, *Cura7*, and *Genicure*.

SFOI: Following the privatization of production of *Sûr'Eau* in 2001, SFOI, one of Madagascar's largest private sector plastics producers, now locally produces and packages all of PSI's supply of this product.

CARE: CARE and PSI have recently submitted a joint proposal for USAID year-end funds to conduct product research and development to explore the possibility of modifying the current Safe Water Treatment solution, sold under the brand name *Sûr'Eau*, in Madagascar. CARE also purchases *Sûr'Eau* and *SuperMoustiquaire* for distribution at subsidized prices via its networks of community-based agents.

Family Health International (FHI): PSI has collaborated with FHI in Diego in 2001, 2002 and 2003 by providing technical support in commercial sex worker (CSW) peer education trainings and by coordinating the development of a clinic promotional brochure as well as five educational comic books targeted to CSWs. In addition, in 2000 PSI conducted formative research to update *Protector Plus* packaging with the association of CSWs (FIVAMATA) working with FHI in Diego. FHI currently works in Mahajanga and Tamatave, and PSI has plans to collaborate on several projects such as an efficacy study of Cura7.

U.S. Peace Corps: PSI works extensively with Peace Corps volunteers throughout the country to implement community based awareness programs. PSI has maintained links and has done a number of collaborations in 2003 and will be continued in the following years, examples including coordinated mobile video unit performances, development of community based contraceptive distribution activities, peer educator trainings, CSW outreach programs, participation in volunteer trainings, and technical support for IEC/BCC activities.

Linkages: PSI has worked with Linkages in the following ways in the past:

1) PSI medical detailers have helped identify and invite doctors to the Méthode d'Allaitement Maternelle (MAMA) training (promotion of breastfeeding as best food for children under 6 months of age and also as a method of family planning)
2) PSI medical detailers have distributed brochures concerning "MAMA" to the doctors during their visits
3) MVU teams show the "MAMA" spot during presentations concerning *Sûr'Eau* or *Super Moustiquaire*

UNICEF: USAID and UNICEF have been the two main donors for the *Sûr'Eau* project. UNICEF funded *Sûr'Eau* project activities in Tamatave region up to the end of 2002. PSI has also received support from UNICEF for its youth-oriented talk shows, co-funded by the Gates Foundation.

Catholic Relief Services (CRS): PSI and CRS have collaborated on a number of different initiatives, including the distribution of PSI's ITNs to CRS "model moms". CRS is also a major distributor of *Sûr'Eau*, especially after natural disasters. In 2003, CRS introduced voluntary counseling and testing for HIV/AIDS into various clinics that it supports, and PSI is using these as referral centers wherever appropriate.

Adventist Development and Relief Agency (ADRA): PSI has worked closely with ADRA to increase the accessibility of ITNs to specific vulnerable target groups. Together PSI and

ADRA in Madagascar implemented a CDC-funded pilot project aimed at targeting an ITN subsidy to pregnant women and children under five living in rural areas of Tamatave province.

Associations of Commercial Sex Workers: PSI has established relations with numerous associations of commercial sex workers, female and male. Working together with these associations, PSI is able to reach and build awareness among sex workers and to target high risk areas like brothels. In addition, these associations have in place a system of peer sales of Protector Plus condoms.

Private Sector Businesses: PSI has started a work-place initiative in 2002 that will continue to expand and create partnerships. Existing partnerships include projects with duty free factories, the major bank "BNI", the Coca Cola distributor "Star", and the mining company "QMM"

Complementary products

If additional funding becomes available via AIDSMark or outside donors, PSI/Madagascar would be interested in examining the feasibility of developing other maternal and child health products, including:

a) Pre-natal kits to provide expectant mothers with a complete set of information and health products (e.g. iron and folate supplements, de-worming medicine, educational materials on maternal health, a treated mosquito net, schedule of pre-natal visits including IPT regimen) to ensure safe and healthy pregnancy and delivery.
b) Oral Rehydration Therapy kits including clear information on administration of the product as well as guidelines for preventing diarrhea and appropriate actions in the case of complications.
c) De-worming kits for children, which would provide a complete set of instructions to parents for administration as well as guidelines for prevention and appropriate actions in the case of complications.
d) Long-lasting contraception to ensure greater access, compliance and ease of use of contraceptives among interested low-income women.

III. SCOPE OF WORK

A. Goal: Reduce the incidence of STIs including HIV in Madagascar

This intervention aims to reduce STI and HIV transmission and to better manage and treat STIs among high risk groups (in particular youth) through expanding a network of franchised youth-focused RH centers, through the distribution and promotion of pre-packaged STI treatment kits, and through IEC messages focused on promoting delayed onset of sexual activity, decreased number of sexual partners, and where appropriate, correct and consistent condom use among high-risk groups. This intervention will contribute to the Madagascar MOH 2000-2003 AIDS control objectives of a 30% decrease in the STI incidence rate among youth, and a decrease in the prevalence of curable STIs among the general population from 450 to 375 per 100,000.

Condom Social Marketing – *PROTECTOR PLUS*

The purpose of this intervention is to promote later onset of sexual activity, a decrease in the number of sexual partners, and increased use of condoms among high-risk groups.

STI prevalence rates are high in Madagascar and a person with an STI is more susceptible to subsequent HIV infection. Since correct and consistent condom use is an effective method of preventing STIs and HIV, PSI/Madagascar will focus its efforts on reaching high risk groups, improving and expanding both mass media and interpersonal communication, and scaling up condom distribution.

Safe behavior messages to high risk groups include the importance of delaying onset of sexual activity, reducing the number of sexual partners, and consistent and correct use of condoms.

PSI has a staff of doctors in its Community Based Sales (CBS) department. These doctors, who are highly skilled in interpersonal communication techniques, work directly with high risk groups to educate them on the consequences of risky behavior, to train them in negotiating safer sexual behavior with their partners, and to discuss the importance of safe behavior among their peers. These doctors also train CSW peer educators to work with their peers via interpersonal behavior change communication.

In addition to branded promotion of *Protector plus* condoms, PSI distributes generic non-branded condoms enclosed in an educational brochure. Brochures provide information on STI prevention and treatment as well as instructions on correct and consistent condom use. Brochures and samples are provided to participants during Mobile Video Unit and peer education awareness-raising events as well as to doctors during visits of our medical detailing teams.

PSI's IEC campaigns focus messages on delayed onset of sexual activity, decreasing the number of sexual partners in addition to correct and consistent condom use among high-risk groups. PSI is working with the Interdenominational Christian NGO, La Ligue pour la lecture de Bible and other faith-based organizations to tailor messages to target groups.

Additionally, through its social marketing of pre-packaged STI kits (see next section below), PSI is able to distribute condoms to people seeking treatment for STIs, those who are perhaps in the highest risk group of all. Each STI kit contains 7 condoms.

Primary Target Groups

Several target groups in Madagascar are considered at high risk for contracting HIV and other STIs. Based on several risk factors, PSI/Madagascar identified three of these groups as the primary target groups:

- Sexually active young men aged 15 to 24 in urban areas
- Commercial sex workers
- Clients of commercial sex workers, specifically truck drivers, taxi drivers, military men, and miners

Overall, young men more frequently than women report having sexual relations with casual partners (25% vs. 7%), and exhibit low levels of condom use: only 1% of 15 to 19 year-olds and 4% of 20 to 24 year-olds report using condoms in their last sexual contact with a casual partner.[31] Men tend to be the decision-makers in sexual relationships—they often make the choice of whether or not to use condoms, thereby determining whether both they and their partners are protected from possible STI transmission. Quantitative research conducted by PSI/AMMS in Tamatave suggests that men are more likely than women to initiate condom use: among 15 to 24 year-olds who used a condom with their regular partner, 75% of young men report that they suggested using a condom compared to around 37% of young women.[32]

Commercial sex workers (CSWs) have numerous commercial and non-commercial sexual partners and are "core transmitters" of HIV infection in Madagascar. They often do not use condoms with their sex partners, putting them at increased risk of contracting HIV and other STIs and then transmitting these infections on to other partners. Since CSWs rely on commercial sex for income, they tend to be less capable of refusing sex without a condom. In a recent regional study of female CSWs in Antananarivo and Tamatave, approximately 70% of respondents reported having had unprotected intercourse with a client during the last month after he refused to use a condom.[33] The same study reveals that CSWs have an average of six to seven sexual partners per week, including both clients and partners as part of their personal lives.[34]

Informal sex workers, who are often harder to reach as they are less likely to be part of formal organizations, are also at high risk, as their personal risk perception, and thus regular condom use, tends to be lower. This lowered risk perception is largely due to the fact that informal sex workers do not identify themselves as commercial sex workers. PSI activities to reach these informal sex workers include extension work by PSI Madagascar CSW peer educators and outreach activities by the VBC department. Among occasional sex traders who seek care for

[31] Ibid p. 169.
[32] PSI. "Connaisances-attitudes-pratiques des jeunes de 15 à 24 ans de Tamatave en matière de planification familiale, de prévention et de traitement des IST/SIDA." July 2001.
[33] MoH, FHI, Population Council, and USAID, "Recherches Opérationnelles conduites à Antananarivo et Tamatave pour Améliorer la Prévention et la Prise en Charge des Infections Sexuellement Transmissibles (IST) chez les Travailleuses du Sexe à Madagascar," May 2001, p 8.
[34] Ibid, p 4.

genital discharge syndrome in Antananarivo, a 2001 study found the prevalence of cervical infection caused by chlamydia or gonorrhea at 30% and the prevalence of active syphilis at 13%.[35]

Clients of CSWs, in particular truck drivers, taxi drivers, military men, and miners (especially those based around the gem mining centers in Diego and Ilakaka), are at high risk for contracting HIV or another STI because of frequent unprotected sexual contact with CSWs, who are a high-risk group, and low risk perception. Truck drivers and taxi drivers are highly mobile and often separated from their families, increasing the likelihood of multiple partners including CSWs. Most CSWs surveyed in Antananarivo and Tamatave stated that their most common clients are truck drivers and taxi drivers.[36] It is estimated that there are over 43,000 long-distance truck drivers in Madagascar,[37] with a concentration of truck drivers, as well as taxi drivers, in major towns such as Antananarivo, Diego, and Tamatave. Clients of CSWs usually have the decision-making power regarding condom use and often do not suggest using a condom because they view a partner as safe unless that partner shows external signs of infection (PSI Qualitative Study with CSWs and their clients; Tana and Diego, 2002). Clients also do not view STIs and HIV as a serious problem because these diseases are considered curable and clients feel that they are not one of the groups at risk for STIs and HIV (PSI Qualitative Study with CSWs and their clients; Tana and Diego, 2002). Work with military men and miners will center around their encampments.

Secondary Target Groups

Certain groups are not at high risk for STI and HIV infections, but do contribute to primary target group members' ability and willingness to change behaviors and purchase condoms. The three major secondary target groups in 2003 are:

- Parents
- Religious authorities
- Sales agents (vendors and distributors)

PSI will seek the social support of these three groups, through an advocacy campaign that will include the integration of these groups in the development of IEC/BCC campaigns and prevention interventions, including specific messages on delayed sexual onset and partner fidelity, as well as use of condoms.

[35] Behets F, et al, "Sexually transmitted infections and associated socio-demographic and behavioural factors in women seeking primary care suggest Madagascar's vulnerability to rapid HIV spread," *Tropical Medicine and International Health*, Vol. 6, No. 3, March 2001, pp. 202.

[36] MoH, FHI, Population Council, and USAID, "Recherches Opérationnelles conduites à Antananarivo et Tamatave pour Améliorer la Prévention et la Prise en Charge des Infections Sexuellement Transmissibles (IST) chez les Travailleuses du Sexe à Madagascar," May 2001, p 6.

[37] 43,000 truck drivers are registered with OSTIE, a professional syndicate based in Antananarivo.

The stated purpose of this intervention, increasing use of condoms among high-risk groups, with an emphasis on youth, will be achieved by:

Output 1

Increase **informed demand** for condoms, to be measured by *:

- Increase in % of 15-24 year olds who are aware that a person's STI and HIV status cannot be determined by looking at the person.
- Increase % of 15-24 year olds who know that consistent condom use is an effective means of preventing STI/HIV/AIDS transmission.

IEC and Promotion :

The generic communication campaigns will be tailored to the three primary target groups to address barriers to behavior change, promote correct and consistent condom use, and increase knowledge regarding prevention of HIV and other STIs. In addition, messages promoting the dual protection of condoms against STIs and pregnancy will be targeted to youth and CSWs. These generic communication campaigns will complement the STI treatment kit campaign, which will focus on promoting STI health seeking behaviors such as appropriate and complete treatment, partner notification, and visits with qualified doctors. To the extent possible, these behavior change communication products and materials will be developed in collaboration with and distributed through all concerned partners, including the MOH/IEC task force members, our partners, and the secondary target groups.

In 2002 PSI signed a contract with the leading private television broadcaster on the island (RTA) that guaranteed free airtime for all educational programs produced, and reduced rates for all branded product advertising in 2002 and 2003. This contract is currently under renegotiation and PSI may contribute a symbolic fee for airings in the future. Other TV station partnerships are being explored as well. In a survey conducted in Tamatave by PSI in 2001, over 50% of urban youth (male and female) had watched television during the preceding week.

PSI has an in-house radio production studio and a PSI produced resource catalogue with radio actors from all over the country, which enables it to produce local language variations of each message for regional broadcasting and to produce innovative audio products, including radio spots and audio cassettes.

There are 10 "It's my choice" listening groups, which are run by a trained facilitator who brings together a homogenous group of the same 10-15 people each week to listen to the radio show. The facilitator has a discussion guide, as well as questionnaires for the participants which will be sent in to the BCC radio production team. The listening groups allow for continuous feedback regarding the messages in the radio show, as well as being an intense BCC interpersonal intervention. The existing groups are located in Tana and in Tamatave,

* Baseline and target indicators to be determined when 2003 KAP data have been collected and analyzed. An update of these indicator percentage values will be supplied to USAID in 2004, when they become available. KAP surveys will be conducted in 4 of Madagascar's 111 districts.

two towns considered at high risk by the Ministry of Health. PSI plans to work in at least three other high risk towns, adding 15 more listening groups in the next two years.

PSI also makes wide use of mobile video units (MVU), which are essentially traveling road shows comprised of video and live presentation equipment that provides targeted messages based on the audience. There are currently five MVUs operating in four principal regions of the country. By January 2004, three more MVUs, funded by the Global Fund, will be operating and will extend PSI's MVU coverage to all six provinces. The MVU focuses STI and HIV prevention work in urban and peri-urban areas. New videos regarding STI/HIV/AIDS prevention have been developed and others are under production. These videos permit the MVUs to continue to present new and interesting material to stimulate discussion and behavior change communication during their animations. The teams will continue to distribute informational brochures to target groups that address condom use and STI prevention and which contain unbranded condoms during MVU presentations and special events.

Focus on target groups :

Members of primary target groups have low knowledge about the connection between HIV and other STIs and that HIV and some STIs are not curable. Many members of the primary target groups believe that they can tell if someone is infected with a STI or HIV by looking at that person. Members also subscribe to the "trusted partner myth," which reasons that they are safe from STI and HIV infection if they are in a monogamous relationship regardless of the length of the relationship. PSI/Madagascar will address this lack of understanding about HIV and other STIs through comprehensive branded and generic communication campaigns.

To effectively reach each target group, PSI/Madagascar will run activities appropriate for each target group. A general description of these activities is located below.

- *Young Men* will be targeted primarily through MVUs and radio and video mass media campaigns. The multi-town generic and educational campaign aimed at young men "It's my choice" will be reinforced and expanded throughout the country. This campaign includes radio spots, a weekly radio show, radio show listening groups and a fan club, a 1-2 times a month sponsored film or PSI show, and 4 video talk shows. The campaign will be informed by research results available from the qualitative and quantitative research from 2003 linked to Top Reseau, as well as continual monitoring such as the ongoing evaluation available through the PSI radio program listening groups and Radio show fan club.

- *CSWs* will be targeted through interpersonal communication activities. Qualitative research conducted by PSI and FHI in 2002 as well as continuous contact with the target group will inform and guide the communication activities with CSWs. Specially designed audio cassettes will continue to be created and distributed among CSW groups, as done in 2003. In collaboration with FHI in Diego, six CSW educational comic books called "Gazety" have been produced in Sakalava and distributed to CSWs of Sakalava origin. PSI has translated these "Gazety" into the official Malagasy dialect and will distribute them throughout the country. PSI/Madagascar has recruited 17 CSW "peer educators" to be contact and supply

points for their peers to facilitate condom purchases by CSWs. These peer educators have worked with PSI's outreach team to train another 2,645 CSWs from 2002 to June 2003. In 2002, peer educators sold condoms to other CSWs, totaling 18% of total condom sales. The peer education program with CSWs will be expanded upon and formalized in early 2004 to include more counseling and education sessions held by the peer educators.

- *CSW clients, including truck drivers, taxi drivers, military men, miners* will be targeted through MVUs and interpersonal communication activities. MVU performances will be carried out at military encampments, truck stops and truck associations, bush-taxi stations, and mining towns. After a successful debut in 2002 with cassette production and 240 copies distributed, another series of specially designed audiocassettes will be created and distributed among long distance truck drivers and military men each year. This audio series is done in collaboration with the target group, and includes interviews with truck drivers and their families, comic skits, dramatic stories, interviews with doctors, and music in a fun, easy-to understand format that appeals to truckers. The production of cassettes for the other target groups also follows the same principles. Radio stations in mining towns will be identified, and specially targeted radio PSAs will be aired to reach miners.

In 2003 PSI began collaborating with an Interdenominational Christian NGO, La Ligue pour la lecture de Bible. This organization helped PSI to tailor messages and the storyline for a film regarding adolescent reproductive health. PSI will continue to collaborate with them to develop messages aimed at the above groups that accentuate delayed onset of sexual activity, and on fidelity within marriage.

Additionally, PSI interviewed Pastor Ramino Paul, a national religious leader, for the "It's my choice" radio program on the definition and role of abstinence in combating STI's and HIV/AIDS.

Condom preferences:

In July and August of 2003, PSI conducted a large scale study funded by the World Bank to determine condom preferences among youth. This study was conducted with young men and women 20 –24 years of age, users and non regular users of condoms. The study determined the desired attributes for a new standard condom, and the desired variables for a new luxury condom. This study was an initial phase in the Ministry of Health and the World Bank's plan to procure and distribute condoms on a nationwide basis. The results of this study will help formulate the order for these condoms, and it is possible that PSI will be asked to distribute these new condoms. The standard condom that was found to be most appreciated by the target groups is cylindrical, transparent, and without odor. The novelty condom most appreciated is of gold color, with a banana odor, and would come in two different forms – one with a texture that resembles an artistic design—the other with ribbing and studs.

The standard condom would replace the existing Protector Plus, and the novelty would be a brand extension. If this change in condoms occurs, PSI will be relaunching Protector Plus and its extension in 2004. The branded campaign will focus on this launch, and on emphasizing the new attributes of the two condoms.

Until there is a change in condom type, the branded campaign will continue to focus on the positive image of *Protector Plus* condoms – that of a high quality condom that is "Plus Fin, Plus Fort" – through the use of existing promotional songs, music videos and televised commercials. In addition, new radio and video commercials continue to highlight the emotion based positioning for *Protector Plus* condoms. MVU promotional sales focus on the positive attributes of condoms and on Protector Plus's youthful image. Brand awareness is very high, so the emphasis of the behavior change communications will be on educational and generic messages.

Output 2

Increase **access** to *Protector Plus* condoms at retail outlets nationwide, to be measured by:

- Increase by 500 the number of retail outlets that sell *Protector Plus* each year.
- Increase in % of bars and nightclubs that sell Protector Plus from 44% to 50%.
- Increase from 28.5% to 33.5% of outlets in rural areas that sell *Protector Plus.*
- Increase from 53% to 63% of wholesale outlets servicing retail outlets that sell *Protector Plus.*
- Assure that less than 5% of urban youth in Top Réseau project areas think that condoms are difficult to find.

To achieve the above objectives, PSI/Madagascar will continue to expand its distribution system for *Protector Plus*. Currently the distribution system is comprised of 24,000 sales points nationwide and a regional network of quality reproductive health service providers. PSI's long term distribution strategy is to encourage existing and natural connections through wholesalers and sales points. PSI encourages retailers to acquire stock directly from wholesalers. A system of depots was established in 2001 throughout the country, which facilitates the uplifting of stock for distribution to wholesalers. At the end of 2003, a review and evaluation of the existing distribution system will be conducted. The results from this evaluation, conducted by outside consultants, will be used to tailor the system to increase the efficacy and capacity of PSI's distribution force.

Focus on high risk zones:

In response to the CNLS declaration of 20 high risk zones for STIs and HIV/AIDS in Madagascar, PSI has prepared and is implementing a *Stratégie Zone Sensible* to mobilize resources ensuring greater coverage of distribution, promotion, and education activities in these districts.

Activities in the 20 High Risk Zones include:

- Organization of five STI and HIV/AIDS prevention related special events per month by PSI's MVU teams (Film projections and animations at public events, military bases, and local associations.)
- "Night Visits" by the Cinemobile and Community-based sales teams to animate local bars/nightclubs with educational message about STI and HIV/AIDS prevention and by the distribution teams to assure sufficient availability of stock.
- Expansion of contracts with radio and television stations in the 20 high risk zones and increased number of airings of spots and the educational program "It's my Choice".

- Inclusion of one well-respected political, health, or youth leaders in the "It's My Choice" program from one high risk zone each month.
- Increased frequency of visits, at least one per month, by the distribution teams to ensure accessibility of condoms in each of the 20 high risk zones

With its existing MIS system, PSI is able to monitor and report specifically on sales of *Protector Plus* and distribution of free condoms with educational brochures that occur in the 20 high risk areas for HIV/AIDS transmission ("zones sensibles") identified by the CNLS. For example, in 2003, some 80% of total sales of *Protector Plus* were in these 20 zones, which comprise only around 20% of the population of Madagascar (INSTAT 2001 data). See APPENDIX B for more details of *Protector Plus* sales by district in Madagascar in 2003.

PSI/Madagascar continues to engage in numerous activities to expand distribution. A sample of these activities follows.

- Monitor sales staff
- Provide training to sales staff
- Recruit 500 new retailers per year
- Recognize loyal wholesalers
- Motivate wholesalers to develop customer loyalty
- Run a sales promotion at wholesale level and at retail level
- Produce and encourage use of a system of wholesaler order cards
- Organize promotional sales at retail point of sale level in collaboration with MVU team
- Collaborate with partner organizations
- Conduct night visits to nearby points of sale, such as hotels and restaurants

Please see Appendix B for a map of *Protector Plus* sales for January to September 2003 and Appendix C for annual log frames with sales targets for condoms.

Comprehensive STI Case Management – *Cura7 and Genicure*

The purpose of this intervention is to increase the use of pre-packaged STI therapy among people with STIs.

The Comité National de Lutte Contre le VIH/SIDA (CNLS), the MOH, and the donor community have placed increasing emphasis on the prevention and treatment of STIs in Madagascar as a way of preventing an HIV/AIDS transmission in Madagascar. Public sector ability to respond to the level of need with current tools is very low. Also, the level of quality of STI management among providers is also considered very low in comparison with international standards and indicators.

In August 2002, PSI launched an STI treatment kit under the brand name *Cura7*. This new kit contains the antibiotics (ciprofloxacin and doxycycline) recommended by the MOH to treat gonorrhea and chlamydia, prevention products (condoms and partner referral cards) to prevent re-infection and promote partner referral, and simplified IEC materials to communicate key messages. The kits are intended as an aid to both health providers and patients for correct diagnosis and treatment of STIs. Research on similar kits in other countries has shown that kit users report higher cure rates, condom use and rates of partner

referral.[38] With its own funding, PSI has made this product available in pharmacies throughout Madagascar, and has incorporated it into private sector doctor trainings in syndromic STI case management. The product has been a great success. PSI has surpassed its annual 2003 private sector sales objectives for *Cura7* in the first eight months of the calendar year. *Cura7* has been approved and endorsed by the MOH and other partners. This AIDSMark project will ensure the continued distribution, promotion and evaluation of *Cura7*.

Genicure, the new treatment kit for ulcerative STIs (syphilis and chancroid), will also be supported throughout the AIDSMark project period by AIDSMark, the World Bank and other donors. This kit contains two different antibiotics (benzathine penicillin and ciprofloxacin) as well as similar education and prevention tools as the *Cura7* kit.

The primary target groups for STI treatment kits are the same as the target groups for *Protector Plus*: young men between 15-24; clients of commercial sex workers (truckers, taxi drivers, military men and miners) and commercial sex workers.

In addition to gender and lifestyle/based target groups, STI kits will also initially target urban populations and expand to rural areas from there. Through the existing network of urban pharmacies, dispensaries, and rural *dépôts de medicaments*, PSI has already penetrated urban and is beginning to penetrate rural markets.

The secondary target group for STI kits includes medical prescribers and dispensers (doctors, pharmacists, nurses, sales people at *depots des medicaments* and other health practitioners). In Madagascar, prescribers maintain a particularly strong influence, since pre-packaged STI therapy kits are distributed under prescription. PSI will continue to promote the kits to health practitioners through medical detailing visits and syndromic approach training courses. Between October 2002 and September 2003, PSI trained 781 physicians in syndromic management of STIs and will have trained 2000 by the end of the calendar year. This number represents approximately 50% of the estimated number of private doctors practicing in Madagascar. PSI will also engage in continued advocacy work to convince the MOH, the national order of doctors (ONM) and the national order of pharmacists (ONP) to enable private physicians to sell STI kits to patients during their initial visit.

Output 1
Increased access to appropriate affordable STI therapy among high risk groups, to be measured by:

- Branded PPT kits sold in over 300 urban and rural outlets by end of project
- 90% of urban pharmacies stock STI kits by end of project.
- 75% of TOP Réseau service providers correctly diagnose and prescribe correct treatment to clients presenting selected syndromes by end of project.
- 1200 service providers trained in correct STI diagnosis and treatment by end of project.
- Increased % of youth who think that STI medications are affordable

Activities planned to achieve this output include expanding and improving the work of PSI medical detailers with an aim at increasing sales continuously every year of the project,

[38] B Jacobs et al; "Social Marketing of pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda" International Journal of STD & AIDS 2003; 14: 216-221.

reinforcing and expanding the private distribution network, and improving collaboration with the MOH. Plans involve providing initial and refresher training annually to 300 to 400 private sector doctors in the syndromic approach to STI management (including the use of counseling flipcharts), recruiting three additional pharmaceutical wholesalers and 15 new NGO/business dispensaries and ensuring that 90% of urban pharmacies stock and dispense the STI kits.

Output 2
Improved knowledge of and attitudes toward STI treatment among high risk groups, to be measured by:

- Increased % of youth who have heard of *Cura7*
- Increased % of youth who have heard of *Cura7* that know at least one STI it treats
- Increased % of youth who have heard of *Genicure*
- Increased % of youth who have heard of *Genicure* that know at least one STI it treats

Activities planned to achieve this output include branded and generic communication campaigns. Generic communications will include broadcasting via national and regional television educational programming and spots targeting urban youth and commercial sex workers. Branded communications will include promoting *Cura7* and *Genicure* in professional medical and pharmaceutical journals and increasing the profile of *Cura7* and *Genicure* at points of sale. These will involve the development of visual aids describing the benefits of *Cura7* and *Genicure* for prescribers and dispensers and on-going informational visits to prescribers and dispensers where PSI medical detailers share sample products and promotional/instructional articles. Also, STI kits are a vital complement to the adolescent reproductive health provider network activities (mentioned later in this document), such that the kits simplify and promote access to STI treatment for Madagascar's vulnerable, sexually active youth.

In the first year of this project, an evaluation of both the effectiveness and efficacy of *Cura7* will be conducted, through other funds. The effectiveness evaluation will focus on several behavioral factors, including the extent to which the kit promotes a greater rate of treatment compliance, partner referral for treatment, and condom use during and after treatment. The efficacy evaluation will determine, through biological testing, if the antibiotics contained in the kit and the prescribed dosage are efficacious in "curing" the patient. In other words, the study will test whether or not the drug combination is successful in combating the strains of gonorrhea and chlamydia found in Madagascar.

Communications Activities by Target Group

Medical Prescribers and Dispensers – will be targeted through *Le Mensuel*, a monthly newsletter targeted to medical doctors produced by PSI, medical detailer visits, continuing educational opportunities, IEC materials and other informational supports developed by PSI.

Young Men (15-24) – will be targeted through the generic campaign "It's my choice" shared with *Protector Plus* aimed at young men. The campaign includes radio spots, a weekly radio show, sponsored educational films, and 4 video talk shows. In order to communicate specific STI treatment messages, PSI will air 3 generic television spots to increase personal risk perception and general knowledge about the transmission of STI/HIV especially among youth, building on those already produced through previous funding. In addition to broadcast

media, PSI will also conduct peer- education sessions and produce and distribute educational posters for doctor's waiting rooms and articles in youth magazines.

Clients of Commercial Sex Workers – will be targeted through print media including articles in magazines and dailies, and educational stickers visible in a variety of locations. In addition to print media, CSW clients will also be reached through interpersonal communications. A second series of specially designed cassettes with STI treatment messages will be targeted and distributed to truck drivers. PSI will transmit through these activities messages that build a culture that finds it socially unacceptable to engage in sex outside of marriage without a condom.

Commercial Sex Workers - will be targeted through interpersonal communication activites that utilize and build upon existing networks of CSW associations and CSWs already trained as peer educators. Key messages will place emphasis on recognizing STI symptoms, modes of STI transmission and the relationship between STIs and the increased risk for contracting HIV/AIDS.

Please see Appendix C log frames for annual STI treatment PPT sales targets.

Franchised Reproductive Health Services for Adolescents – *TOP Réseau*

The purpose of this intervention is to increase preventive and care-seeking behaviors practiced by youth in Diego and two other high risk urban centers of Madagascar

In January 2001, PSI established a franchised network of adolescent reproductive health service providers in the eastern province of Tamatave. This project was initiated with support from a multi-country grant from the Gates Foundation for the improvement of adolescent reproductive health in Africa. The project design is based on lessons learned from successful approaches in other countries and on proven behavior change theory. Since December 2000, PSI has formed a pilot network of 17 pre-existing health centers, comprising 30 specially trained doctors in Tamatave and another 33 centers, comprised of 50 doctors in Antananarivo, under the brand name *TOP Réseau*, a name that has been promoted to mean welcoming, confidential, affordable, quality health services for youth.

Selected health clinics were recruited for participation in the network and providers were trained in the syndromic approach to STI case management, modern contraceptive methods, and youth counseling techniques. Providers agree to uphold a minimum set of standards (ranging from clinical standards to methods of interpersonal communication to following *TOP Réseau* branding guidelines) defined in the Franchise Service Manual (fully revised in August 2003), and to offer a special reduced price for youth seeking counseling and reproductive health care.

In exchange, the Social Marketing Project uses a mix of television and radio advertisements, mobile video units, and peer educators to promote the network under the *TOP Réseau* brand. A complementary educational campaign promotes healthy behavior such as delayed sexual debut, partner reduction, prompt STI treatment, and condom use. In its first three years of activity in Tamatave, the project has demonstrated notable success: the network provided

reproductive health services to 15,493 youth, out of which 40% of female consultations and 85% of male consultations were for STI services.

Furthermore, the project has demonstrated improvements in knowledge, attitudes and behavior among the target population, encouraging PSI to continue the approach. Positive results of the pilot program KAP study, which compared those with little to no exposure to *TOP Réseau* activities to those with medium and high exposure, include the following:

Among both male and female youth:

- Increased knowledge/confidence that condoms prevent HIV/AIDS (women with weak exposure: 81.6% vs. women with strong exposure: 95% and men with weak exposure: 87.4% vs. men with strong exposure: 97.8%)
- Increased knowledge regarding where to find condoms nearby (women with weak exposure: 80% vs. women with strong exposure: 92.2% and men with weak exposure: 55.4% vs. men with strong exposure 85.3%)
- Decreased shyness to buy condoms (women with weak exposure: 52.6% vs. women with strong exposure: 41.8% and men with weak exposure: 26.8% vs. men with strong exposure:17.8%)

Among male youth:

- Increased knowledge of where to find affordable STI services (weak exposure: 91.5% vs. strong exposure: 98.4%)
- Decreased belief that STI services are expensive (weak exposure: 42.2% vs. strong exposure: 32.7%)
- Increased consistent condom use with occasional partners (weak exposure: 7.9% vs. strong exposure: 25.5%)

Among female youth:

- Increased use of modern family planning methods (weak exposure: 31% vs. strong exposure: 55.1%)
- Increased perceived risk of HIV (weak exposure: 28.3% vs. medium to strong exposure: 39.1%)

Due to this success, PSI has plans to extend this network to other large cities in Madagascar. During the first year of this AIDSMark project, PSI's *TOP Réseau* network will be expanded from the 17 existing sites in Tamatave to an additional 10 sites in Diego (to be launched in January 2004). PSI has also secured additional support from the Global Fund to introduce the network to further sites in Antananarivo and Fort Dauphin in Tuléar province in 2003 and 2004 respectively. Diego and Fort Dauphin are priority sites identified by USAID, and are both included (along with Antananarivo) in the CNLS's list of 20 priority zones of high HIV transmission risk. The funding requested through this AIDSMark proposal focuses mainly on supporting the Diego-based network but will include some funding for other existing sites to ensure that a minimum 5 years of support provides the initial "grounding" necessary to ensure sustained service provision and quality.

Primary Target groups

Young men aged 15-24: In general, young men more frequently than women report having sexual relations with casual partners (25% vs. 7%), and exhibit low levels of condom use. Only 1% of 15 to 19 year-olds and 4% of 20 to 24 year-olds report using condoms in their last sexual contact with a casual partner.[39] As mentioned earlier, the fact that men are more likely to initiate condom use makes it that much more important to target them with prevention and behavior change messages.

PSI has found that young men are far more difficult to convince than women to use *TOP Réseau* ARH services. Although males did not increase proportionately in their use of STI services as compared to women in the first two years of the pilot, they did increase in number. This demonstrates some progress. Also, the fact that a greater percentage of men exposed to *TOP Réseau* understand that STI services are not expensive and a greater percentage of them know where to obtain these services shows that increased service utilization is slowly being attained through *Top Réseau.* In order to build on some initial successes and to target the population with the most power to affect condom-related behavior change, PSI will continue to target mass media and interpersonal communication activities to young men with emphasis on delaying sexual onset, reducing number of partners, increasing consistent condom use, and increased use of STI treatment services.

Young women aged 15-24: Young women are particularly vulnerable to the spread of HIV/AIDS and other STIs, due to a combination of biological factors (male to female heterosexual transmission is more efficient than vice versa) and social and economic factors (such as lower disposable incomes and the inequalities of power within sexual relationships). As mentioned earlier, a recent sero-prevalence survey has shown that women 15 to 19 years of age and even more so those just under 15 are at the highest risk of HIV infection.[40] Despite the fact that young women generally show more willingness to adopt safer sexual practices, they are usually limited in their ability to do so. PSI will target young women using interpersonal activities designed to delay sexual onset, decrease number of partners, and increase condom negotiating skills and correct condom use. Similarly, PSI will promote, through these same means, correct STI care-seeking behaviour including greater utilisation of *TOP Réseau* clinic services.

Commercial sex workers: As mentioned earlier, the lifestyle of male and female sex workers puts them at great risk of contracting HIV and other STIs and passing them on to their partners. MOH research found that CSWs tend to be less capable of refusing sex without a condom, as described earlier. The same research reveals that CSWs have an average of 6 to 7 sexual partners per week.[41] Informal sex workers are also at high risk, as their personal risk perception, and thus their regular condom use, tends to be lower. Many sex workers automatically fall into the 15-24 age groups that are already covered under the project, but

[39] PSI. "Connaisances-attitudes-pratiques des jeunes de 15 à 24 ans de Tamatave en matiere de planification familiale, de prevention et de traitement des IST/SIDA." July 2001..
[40] Etude Combinée des Séro-prévalences de l'infection à VIH et de la Syphilis chez les femmes enceintes à Madagascar, Ministère de la Santé, Juin 2003
[41] PSI. "Connaisances-attitudes-pratiques des jeunes de 15 à 24 ans de Tamatave en matiere de planification familiale, de prevention et de traitement des IST/SIDA." July 2001..

PSI has found that doctors in the network are also willing to accept CSWs, who may be outside the age group but who have been identified/targeted through *TOP Réseau* peer educators.

Secondary target groups

Medical and Paramedical service providers (there are around 4,000 private medical providers in Madagascar, and many more para-medical providers in both formal and informal sectors). Service providers are crucial vectors of information for potential condom users and STI service clients and have the ability to inform and influence clients in a confidential setting. Service providers will be trained in the syndromic approach to STI diagnosis and case management, adolescent sexual and reproductive health, and client counselling techniques. Service provider training is adolescent-focused, and centers around the Bruce-Jain quality of care model.

Target groups are expected to benefit from increased awareness, improved personal risk perception, delayed sexual onset, reduced number of partners, greater empowerment to prevent and treat STIs, and easier access to related health products and services. Service providers will benefit from enhanced skills and ability to provide quality services. The Malagasy population as a whole will benefit from decreased prevalence of STIs, which in turn has an inhibiting effect on the rapid development of an HIV/AIDS epidemic.

PSI will seek additional funding from outside sources in order to include two new services to TOP Réseau service "package' by the end of the proposed project period: HIV voluntary counselling and testing (VCT) and post-abortive care (PAC) services. The latter is extremely important in a nation where 1 in 10 women admitted to the largest maternity in Antananarivo are admitted for post abortive complications and 47.3% of annual maternal deaths in public hospitals throughout the nation were related to abortion.[42]

Immediate project targets:

- By January 2004 PSI will launch *TOP Réseau* in Diego.
- Between January and September 2004 (year one of this project), *TOP Réseau* will see 2,000 ARH clients in Diego alone.
- By the end of the project period (September 29, 2007) *TOP Réseau* will see 101,920 clients in Diego, Antananarivo, Majunga, Fort Dauphin, and Tamatave.

Output 1
Improved access to high-quality youth-friendly reproductive health services, to be measured by:

- Increase in % of 15-24 year olds reporting that they can identify a facility where they can receive STI services
- Increase in % of 15-24 year olds who believe STI treatment services are affordable
- At least 101,920 clients served within the project period

[42] RANJALAHY RASOLOFOMANANA J. et. Al., « Introduction des Soins Obstétricaux d'Urgence et de la Planification Familiale pour les Patientes Présentant des Complications Liées à un Avortement », Février 2002.

Activities planned to achieve this output will include expansion of the franchised service network through assessment, recruitment, and branding of a total of 10 new *TOP Réseau* clinic sites over the next year in Diego where the HIV prevalence rate is estimated to be the highest in the nation (1.51% among pregnant women). Also, the network will be expanded to two other high risk towns, Fort Dauphin and Majunga, and enlarged in Antananarivo, under support from the Global Fund such that there will be *TOP Réseau* networks functioning in 5 high-risk cities by the end of the project period.

After nearly three years of project activities in Tamatave, several resources exist to aid the efficient expansion of this franchise. These include a Franchise Service Manual (which defines standards, training needs, and contract terms), a process for selecting and evaluating potential clinic sites, a computerized data collection and information management system (revised to more effectively track records of repeat infections and types of STI infections), STI prevention kits (including condoms, instructions, and partner referral cards), the newly developed PPT kits, a flipchart to guide syndromic STI case management and FP counseling, as well as several branded promotional items. Training envelops several aspects of quality of care provision including:

- International standards on clinical care (the WHO syndromic approach to STI management, modern family planning methods)
- Communication techniques for counseling (including use of specific tools such as the STI flip chart)
- Adolescent physiology (including the changes experienced during puberty)
- Ensuring clients are welcomed in a friendly, non-judgmental way
- Efficient clinic management.

PSI will maintain quality of care through quarterly re-training of participating providers. These sessions focus on repeating and reinforcing subjects presented during the initial training. The re-training sessions also give providers the opportunity to discuss practical issues with trainers and other providers. The regular contact with *TOP Réseau* doctors will allow PSI to eventually introduce new IEC materials, products and services. PSI selects the topics to be covered during re-training sessions after analyzing results of exit interviews, mystery client surveys, supervision visits, and the requests of the providers themselves.

Ongoing monitoring of the quality of clinic services will be carried out through services data analysis, supervisory visits, mystery client surveys, and regular re-training sessions.

As in Tamatave and Antananarivo, the network will be promoted through branded mass media (including television, radio, posters and MVUs) and interpersonal activities (including peer education and community-based sales). The promotion component will be tied to activities designed to increased risk perception in Output #2 resulting in improved informed demand for services. Communication tools developed for the peer education component of this project include a training manual, educational resources, handouts (brochures, flyers, etc.) and presentation formats. A song and music video that have been developed to promote the *TOP Réseau* network will also be used in the new sites.

Output 2

Increased informed demand for condoms and STI treatment services among sexually active youth, to be measured by*:

- Increase in % of 15-24 year olds who can identify two or more STI symptoms among males.
- Increase in % of sexually active 15-24 year olds who think they would be at medium/high risk for HIV/AIDS if they do not consistently use a condom.
- Increase in % of 15-24 year olds who recognize that they can reduce their risk of STIs if they limit themselves to one or very few partners
- Increase in % of 15-24 year olds who cite that condoms offer the dual benefits of protection against unwanted pregnancy and infection from STIs

* Note: baselines and targets will be established once baseline figures for new expansion sites are available.

Activities planned to achieve this output include the implementation of a comprehensive behavior change communication campaign that will incorporate and complement the activities described in the promotion of *Protector Plus* and *PPT kits* above. The intervention's communication strategy calls for a balance of mass and interpersonal communication activities to achieve maximum impact. A solid base of already existing BCC (Behavior Change Communication) products and tools at PSI will facilitate the expansion and intensification of communication activities. All behavior change communication messages are developed based on quantitative and qualitative research intended to identify key barriers and principal motivating factors to achieving healthy behavior among key segments of the population. Materials are pre-tested among target audience members before large-scale use.

- The existing generic mass media communication campaign "It's my choice", targeting primarily young men will be used to raise awareness about HIV and other STIs, and condoms as a method of preventing transmission.
- A branded mass media campaign will promote *TOP Réseau* as an affordable, confidential, high-quality source of reproductive services for youth.

The existing peer education program promotes delayed sexual debut and partner reduction, promotes condom use for sexually active youth, raises STI and pregnancy awareness, and promotes *TOP Réseau* clinic services. Peer education activities will be expanded to all new *TOP Réseau* sites.

Output 3

Improved self-efficacy to practice safer sexual behavior among youth, to be measured by*:

- Decreased median age at which youth begin sexual activity
- Decreased percentage of 15-24 year olds who report that they hade more than one sexual partner in the last year.
- Increased percentage of 15-24 year olds who report talking with a friend about STIs in the past 12 months
- Increased percentage of 15-24 year–old females who report that they can convince their regular partner to use condoms.

*Note: baselines and targets will be established once baseline figures in new expansion sites are available.

Activities for this output include interpersonal communications for youth through peer education. International practice and experience has identified a number of characteristics of effective sex and HIV education programs. In *Emerging Answers*, a summary of research findings on programs to address teen pregnancy and sexual behavior (Douglas Kirby, May 2001), 10 key elements are described, which have been used as a base by PSI in developing its interpersonal communications program. These include focusing on a small number of sexual behaviors, reinforcing key messages, providing basic accurate information, using methods that involve participants, developing negotiation and refusal skills, developing behavioral goals, and delivering messages through trained, motivated and capable peers.

Peer education allows messages to be highly tailored to specific target groups. It is used to address specific barriers to abstinence, partner reduction and condom use and to promote the use of youth-friendly clinic services provided by the *TOP Réseau* network. Such interpersonal activities have been found to be the most effective way of motivating sustained behavior change. PSI has two years of experience with youth peer educators that have been conducting sensitization sessions in the province of Tamatave, associated with the existing *TOP Réseau* project. The intimate size of the sessions (groups of 13 on average) allows for a highly participative atmosphere and discussion of sensitive topics. During these sessions, participants typically enact role plays that help them build skills and confidence in areas such as negotiating with their partner and correct use of condoms. To maximize the impact of these sessions, educators gather homogeneous groups of youth and tailor the content of each session to the make-up of that group. During sessions with younger audiences, for example, educators place greater emphasis on abstinence and the benefits of delaying sexual activity.

In addition to the group sessions, peer educators conduct individual client contacts through outreach to popular youth "hang outs", schools, clubs, associations and on the streets and in home visits. These intensive behavior change communication sessions are largely focused on *TOP Réseau* clinic services promotion, but also include prevention education. AIDSMark support will enable the recruitment of 10 new youth peer educators to be based in Diego and 10 in each of the two expansion sites in 2005.

Please see Appendix C log frames for annual Franchised Reproductive Health Services for Adolescents client visit targets.

B. Goal: Improve Reproductive Health of Women in Madagascar

Hormonal Contraceptives – *Confiance & Pilplan*

The purpose of this intervention is to increase the use of hormonal contraceptives among specific age groups of women of reproductive age retailed through the private sector.

Primary target groups

Oral contraceptive promotion will be targeted to *women in union aged 20 to 34 in rural and urban areas*. Oral contraceptives are an ideal option for birth spacing, as there is an almost immediate return to fertility after discontinuing use. These tend to be better suited to younger women, many of whom wish to have additional children.

Injectable contraceptive promotion will be targeted to *women in union aged 25 to 44 in rural and urban areas who already have two or more children.* Injectable contraceptives are promoted among slightly older women, who tend to prefer a longer-lasting, reversible, and more discreet modern contraceptive method.

Secondary target groups
Secondary target groups for both products include *health service providers*, who play a large role in the education of clients and prescription of contraceptives, and *pharmacists*, who constitute the most important distribution path for the products and are also a vital source of information for clients.

Dual Protection

Due to the high prevalence of STIs in Madagascar, women who chose hormonal methods are still at high risk of infection, even if they are protected from unwanted pregnancy. The fact that hormonal contraceptives do not provide protection from STIs (including HIV) is made clear in all product literature, during generic radio spots promoting the products, during training sessions for doctors and during regular follow-up visits to doctors and pharmacists made by PSI's medical detailers. Hormonal users who have more than one regular sexual partner, are therefore encouraged to engage in dual method use (hormonal method against pregnancy, condoms against STIs). PSI does not promote *Pilplan* or *Confiance* to groups of women who are at higher risk of contracting STIs, particularly adolescents and commercial sex workers. For these groups, PSI strongly promotes the dual protection benefits of condoms (against both pregnancy and STIs).

Output 1
Increase **informed demand** for hormonal contraceptives nationally, to be measured by:

- Increase in *Pilplan, Confiance* brand awareness and acceptance among urban pharmacists and rural *dépôts de médicaments* owners.
- Increase in *Confiance* and *Pilplan* brand awareness and acceptance among service providers including nurses and midwives.
- Increase in *injectable contraception* and *oral contraception* awareness and acceptance among women 15 to 24 years of age.

Activities planned to achieve this output include conducting a generic communication campaign for oral and injectable contraceptives through mass media and community activities. The profile of the products will also be increased through point-of-sale materials.

The generic information, education, and communication strategy will seek to educate target groups about the advantages of birth spacing and using hormonal contraceptives for family planning, as well as clarifying product side effects. Common misconceptions that will be addressed in interpersonal and mass media communications are that modern contraceptives contribute to congenital malformations and cancer as well as have undesirable side effects such as abdominal pain, future sterility, and of specific concern to male partners, vaginal drying.

At this time branded communications for pharmaceutical products is forbidden by Malagasy legislation. Therefore it is not possible to broadcast television or radio advertisements directly

mentioning *Pilplan* or *Confiance*. However, PSI plans to display product logos with a slogan at the end of newly developed television advertisements. In addition to advocating legislative change to allow branded advertisements for these pharmaceutical products, PSI will produce specialized slogans for prescribers and women within the target groups.

PSI will continue to produce and air generic radio spots and radio shows, putting particular emphasis on reaching rural areas. All spots are produced in local dialects and aired on local radio stations in addition to the national radio station. The popular maternal and child health PSI mass media campaign "Trust and Confidence" which includes a weekly radio show and radio commercials, and a once a month sponsored film or PSI produced show on television, will continue to provide family planning information. This information includes dual protection messages aimed to women who are at high risk of STIs. The radio show is informed by target group participation in the production and listening group feed-back.

A four-part video soap opera dealing with family planning as well as STI/HIV prevention issues will be aired on television and through the mobile video units. During the MVU screenings of this soap opera, trained PSI representatives will be present to give information and answer questions about family planning methods.

PSI will continue to strengthen interpersonal communication for hormonal contraceptives by extensive training of private health providers including: vendors in pharmacies, pharmacists, and *dépôts de médicaments* to ensure that consistent, high-quality and informed advice is available to women and their partners.

Output 2

Increase **access** to *Pilplan* oral contraceptives and *Confiance* injectable contraceptives in appropriate retail outlets nationally, to be measured by:

- Increase in number of *dépôts de médicaments* that stock *Pilplan* and *Confiance*
- Increase in percentage of outlets that sell *Pilplan* and *Confiance* at the recommended retail price

Activities planned to achieve this output include the deployment of the medical detailing team to facilitate sales to private and public sector outlets. PSI's medical detailing network will be extended to cover all six provinces in Madagascar, with an increasing focus on detailing visits to rural communities. *Pilplan* and *Confiance* are already available in around 92% of pharmacies (which are predominantly urban) in Madagascar. The program will improve coverage of rural areas by geographically re-organizing detailing activities, and explore new avenues for distribution, such as community based agents in rural areas, and even church-affiliated health clinics. In September 2003, the MOH officially endorsed community based sales of oral contraceptives by community health agents. PSI has begun collaboration with organizations such as the U.S. Peace Corps to carry out pilot community-based sales activities, which will help determine an optimal model for working in other underserved rural areas.

As with the STI kits, PSI will advocate for direct sales of contraceptives, and in particular social marketed products, by clinics/physicians. PSI intends to secure a waiver for private physicians for certain classes of products related to contraception and STI treatment so that

they may procure these products from pharmaceutical wholesalers and/or pharmacies and sell them directly to their clients.

PSI will also develop and distribute new IEC and promotional materials to participating sales outlets to increase retailer/provider motivation to stock hormonal contraceptives and indicate to consumers where they can obtain the products.

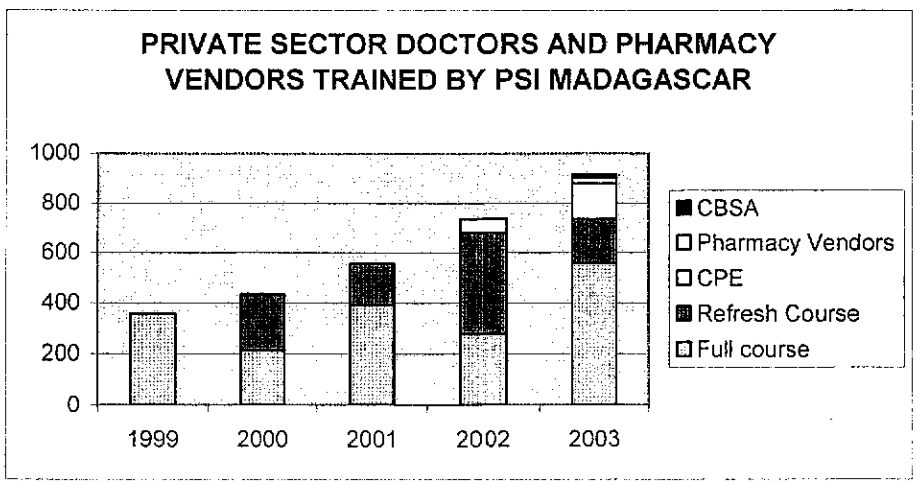
Output 3

Increase private sector capacity to deliver **quality** reproductive health services and products, to be measured by:

- Increase in percentage of *TOP Réseau* providers who correctly counsel new young family planning clients about side effects of oral and injectable contraceptives
- 1200 providers and pharmacists trained in modern family planning methods.

Activities planned to achieve this output include ongoing training of prescribers (clinical providers, pharmacists, and owners of *dépôts de medicaments)* by the medical detailing team. PSI medical detailers and physicians who have been provided in-depth training in each PSI pharmaceutical product including training in side-effects and common misconceptions, which is in turn imparted to the physicians they visit.

In Madagascar, PSI is the sole provider of continuing professional education to private doctors in modern contraceptive methods. Two-day family planning courses cover topics that include reproductive anatomy, counseling techniques, modern contraceptive methods available in Madagascar, and social marketing. Half-day refresher courses answer specific questions from the doctors, including an emphasis on addressing patients' concerns about hormonal product side effects, and common misconceptions (mentioned earlier). The small size of the sessions (approximately 25 participants in each) allows for active provider participation and individual attention. Since the training program began in 1999, total annual sales of *Pilplan* oral contraceptives have more than tripled and sales of *Confiance* injectable contraceptives increased fivefold.



In 2002, PSI Madagascar tailored these training programs to include pharmacists, and in particular the vendors who work in pharmacies, who tend to have the most frequent client contact. In 2003, PSI Madagascar has included a third type of training - continuing

professional education courses (CPE) which combine updates in health practice with product promotion. PSI will also organize special training sessions for paramedical professionals. Similar to PSI's approach to STI syndromic treatment approach training, PSI has developed with input from the MOH and other health sector partners a flow-chart-based "flip chart" that serves as both a client educational tool and a family planning provider technical aide. This "flip chart" serves as the core of the training provided to medical and paramedical health workers alike.

Between October 2002 and September 2003, PSI trained 710 physicians and other health workers in modern family planning methods. During years 2004 through 2007, refresher courses for trained prescribers will be offered as well as initial training for new medical school graduates. Overall the trainings will reach approximately 300 to 400 prescribers per year. Additional health worker training will be provided should additional funds be secured.

The quality and effectiveness of the training sessions are monitored by pre- and post-tests, followed up by regular visits by the medical detailing team to ensure problems or misunderstandings are dealt with quickly, as well as through the regularity of the refresher training.

Please see Appendix C log frames for annual oral and injectable contraceptive sales targets.

C. Goal: Improve Maternal and Child Health in Madagascar

Malaria Prevention and Treatment

In May 2003, Madagascar's Ministry of Health named PSI/Madagascar official distributor and promoter of the national program to distribute long-lasting insecticide treated mosquito nets (LLITNs) at the subsidized price of 15.000 Fmg (approximately $2.50).

After much negotiation among government and Roll Back Malaria (RBM) partners, the first 100,000 nets have been ordered and launch plans are underway. The government of Madagascar, with funding from the World Bank, plans to order some 1.6 million nets to be distributed during the next 3 years. The distribution of these nets, in conjunction with the 200,000 LLITNs already sold by PSI via its cost-recovery program, puts Madagascar on the road to meeting the Abuja target:

- By 2005, at least 60% of those at risk of malaria, particularly children under five years of age and pregnant women benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets.

In response to a second Abuja target:

- By 2005, at least 60% of those suffering from malaria have prompt access to, and are able to correctly use, affordable and appropriate treatment within 24 hours of the onset of symptoms.

PSI, in collaboration with the Ministry of Health and Roll Back Malaria partners in Madagascar has developed a new malaria treatment product – pre-packaged chloroquine for children under 5 – which it will soon add to the LLITN it successfully launched in 2001.

The costs of developing and launching this product have been provided by PSI Headquarters in Washington, with additional support this year from AIDSMark. USAID/Madagascar has also provided crucial support in negotiating key elements of product development with MOH and RBM partners

The introduction of a malaria treatment product is leading PSI to work on developing an integrated educational campaign surrounding malaria prevention and treatment. Elements of this campaign, as envisioned to date, will include:

- Brochure for target groups including cause, symptoms, prevention, and treatment facts.
- Informational kit for medical personnel including information on the parasite, its incubation period, diagnosis of malaria, and signs of complication.
- Malaria Day festivals with animations, rapid tests, and free treatment in selected health centers.
- IEC materials for community based agents.

Malaria Prevention – *SuperMoustiquaire*

The purpose of this intervention is to increase the use of long lasting insecticide-treated mosquito nets (LLITNs) among children under five and pregnant women, particularly in rural areas of endemic malaria in Madagascar through:

Output 1: Increase **informed demand** for ITNs, to be measured by * :

- Increase in % of adults who know malaria is transmitted only by mosquitoes.
- Increase in % of adults who know malaria is most dangerous for pregnant women and children under 5.
- Increase in % of adults who cite mosquito nets as a way to prevent malaria transmission.

Output 2: Increase **access** to *SuperMoustiquaire* at points of sale (POS) nationally, to be measured by:

- Increase in % of adults who know where to buy ITNs.
- Increase in % of households that consider ITNs affordable.
- Increase by 500 the number of POS that sell *SuperMoustiquaire* each year.
- Increase from 1.5% to 20% the number of rural sales points that sell *SuperMoustiquaire.*
- Increase from 30% to 40% of wholesale outlets servicing retail outlets that sell *SuperMoustiquaire.*

* Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

Background:

PSI began the LLITN project with a grant from its Washington headquarters. USAID, via AIDSMark, was the first donor to support PSI's initial work in social marketing of LLITNs at a cost-recovery price. From this base, PSI was awarded $2 million from the Global Fund for a three-year program and continues to receive AIDSMark money to sustain programmatic activities.

These funds are now being leveraged to support distribution and promotion costs for the expected five-fold increase in sales of the subsidized LLITN, which will focus on reaching pregnant women and mothers of children under 5 in rural populations and zones of endemic malaria.

Funding from AIDSMark for *SuperMoustiquaire* will be used to complement existing resources, and will focus therefore on improving channels of communication, particularly in rural areas. This includes support for existing MVU teams (that visit mainly rural locations), support for development of educational and promotional materials suited to target groups in rural areas, costs of placing promotional spots on national and regional television channels, and for PSI's community based distribution team that supports NGOs and private entrepreneurs through training of independent sales agents and workplace interventions.

Target groups:

The target groups for this project include young couples aged 20 – 34 with children under 5 years old, and pregnant women in rural endemic areas. Couples are chosen as a target group because parents together make decisions about important purchases for the household (such as nets), but often women are the actual purchasers of what is important for the health and well-being of the family.[43] Couples with children under 5 are targeted, due to the vulnerability of young children, who have not yet developed immunity levels to malaria. Pregnant women are chosen as a target group given their high degree of risk, and the fact that they are more likely to be concerned with their health and well-being during pregnancy.[44]

Achieving Output 1:

In view of the prevailing low knowledge and usage of ITNs, PSI will implement an extensive BCCs campaign to promote the importance of using LLITNs to protect against the mosquitoes that cause malaria. The campaign will include mass media, MVU presentations, and product demonstrations and promotions by community-based sales agents. A rural communication strategy will be developed to optimize impact, even in the hardest to reach zones. Research has begun and will continue to develop messages that are most appropriate and convincing to rural populations. In addition, the new, subsidized consumer price of 15.000 FMG per LLITN is expected to increase demand.

[43] Focus Groups, PSI 2001.
[44] Ibid.

Achieving Output 2:

To further ensure that the increased demand will benefit target groups, PSI has developed IEC and promotional materials, including radio spots, featuring pregnant women and mothers with children under five. For example, new packaging material was designed for the subsidized net, which features an attractive photo of a family (child, pregnant mother, and father) preparing to go to bed, under their *SuperMoustiquaire*. PSI will also continue to promote community-based sales (CBS) via community health agents. Our team of CBS trainers will work with CARE, CRS, and other NGOs to prepare their community agents to sell and/or promote (depending on the NGO's model) the subsidized nets to pregnant women and mothers of under fives via their networks.

Additionally, to meet the estimated five-fold increase in sales and to assure the greatest accessibility of LLITNs, PSI is expanding and reinforcing its distribution system in order to focus more intensively on reaching hard-to-reach rural areas.

Participation of medical personnel, particularly at the health center (CSB) level, will also be an important element in assuring widespread sales of LLITNs in remote areas. PSI plans to work closely with the MOH, Médecins Inspecteurs, and Chefs CSBs to provide starter stock and training in management of a revolving fund and procurement procedures for future net purchases.

Future plans:

A further innovation currently being considered is the possibility of local manufacture of ITNs (nets are currently imported from Asia). In anticipation of the large-scale subsidized distribution funded by the World Bank, PSI invited net manufacturers to Madagascar in early 2003 to review local production capacities. PSI will continue to pursue this possibility as the subsidized net distribution program unfolds.

Additionally, a strategy for eventually reducing the subsidy on LLITNs will need to be developed among MOH and RBM partners in Madagascar.

Continued funding from AIDSMark for the *SuperMoustiquaire* project will complement PSI's close collaboration with MOH and Roll Back Malaria partners, and will add to funds already made available to PSI through the Global Fund.

Please see Appendix B for a map of *SuperMoustiquaire* sales for January to September 2003 and Appendix C for annual LLITN log frames with sales targets.

Malaria Treatment – *Palustop*

The purpose of this intervention is to increase correct and early treatment of malaria by the use of pre-packaged anti-malarials among children under 5 in Madagascar through:

Output 1: Increased **informed demand** and awareness of appropriate use of malaria PPT for treatment of malaria in children under 5, to be measured by *:

- Increase in % of parents who correctly cite three symptoms of malaria.
- % of parents who cite product brand name as an effective malaria treatment for children under 5.
- % of pharmacists/vendors who correctly cite recommended instructions of pre-packaged chloroquine for children under five.

Output 2: Increased **access** to affordable malaria PPT for children under 5, to be measured by:

- % of adults who know where to buy pre-packaged chloroquine.
- % of households that consider pre-packaged chloroquine affordable.
- Increase by 500 the number of POS that sell *PaluStop* each year[β].
- Increase number of POS in rural areas that sell *PaluStop.*[β]
- Increase in percentage of wholesale outlets servicing retail outlets that sell *PaluStop.*[β]

Background:

Palustop is an innovative pre-packaged chloroquine treatment of uncomplicated malaria in children under five. The product includes clear usage guidelines, as well as practical advice for mothers during treatment and appropriate responses in case of complications. *Palustop* will be marketed in conjunction with an educational campaign for parents and vendors. The product's key advantages are the provision of correct dosages, and an increase in treatment compliance.

Two age groups have thus far been developed for *PaluStop*:

- *PaluStop Zazakely* for infants 4-11 months in age
- *PaluStop Zaza* for children 1-5 years in age

Pre-packaged therapy is an essential component in improving home management of malaria. In Madagascar, where an estimated 80% of malaria cases[45] are treated outside of health

* Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

β Estimates based on sale of *PaluStop* in commercial sector.

[45] WHO presentation, "Prise en charge à domicile des cas de paludisme simple", December 2002 at the Conférence Nationale sur la Prise en Charge à Domicile par les Mères des Cas de Paludisme Simple chez les Enfants de moins de 5 ans à Madagascar.

centers and hospitals, home management of malaria is a key component of the *Politique Nationale de Lutte Contre le Paludisme*.

Target groups:

The primary target groups for this project are mothers and caregivers of children under 5. Secondary groups include health agents, pharmacists, and community based agents.

Launch and Distribution:

Production of *PaluStop* is taking place in October 2003, which will be followed soon thereafter, by the launch of the product *Palustop* in the fourth quarter of 2003. To date, 4 television spots and one film have been produced for *PaluStop*, which will be aired on the major stations as well as during MVU projections.

PSI has been developing the distribution strategy for *PaluStop* with various partners including the Ministry of Health and Roll Back Malaria. Support of the medical and pharmaceutical community will be essential to the success of *PaluStop* in Madagascar. PSI is preparing to introduce the product to these communities via a series of meetings with key leaders of the *Ordre National de Médecins, Ordre National de Pharmaciens,* and various *Conseils Régionals de l'Ordre des Médecins* and subsequent presentations of the product during meetings of these professional associations.

PSI will take advantage of the relatively close timing of the launch of *PaluStop* and the subsidized LLITNs in simultaneously recruiting commercial sector points of sale for both products. A PSI distribution survey carried out in 5 provinces in Madagascar in 2002 found that 9% of 'epiceries' currently sell chloroquine in some format (9% in urban areas and 12% in rural) but 62% showed an interest in stocking the product *Palustop*. Sales targets (as specified in the logframes, Appendix C) are based on the proposed wider distribution through shops.

PSI medical detailers and commercial representatives will be trained in the key issues and messages regarding home-based management of malaria and correct promotion of *PaluStop*. They will use talking point sheets, educational brochures, and instructional posters to convey key messages regarding correct instructions so that customers can:

- Identify that *PaluStop* is an anti-malarial
- Confirm the primary symptoms of simple malaria
- Know the warning signs of malaria complications
- Choose the appropriate age group for their child
- Understand that the treatment consists of administering one tablet per day for 3 successive days.

These teams will inform the pharmacists, prescribers, and vendors in their sector of these key messages during initial recruitment visits and will monitor performance during their regular follow-up visits.

Please see Appendix C log frames for annual malaria PPT sales targets.

Home Water Treatment - *Sûr'Eau*

The purpose of this intervention is to increase the use of home water treatment solution among low-income and rural Malagasy households through:

Output 1 Increased **informed demand** for safe water treatment, to be measured by*:

- Increase in % of adults who cite contaminated/dirty water as one cause of diarrhea.
- Increase in % of adults who cite *Sûr'Eau* as a way to purify water and prevent diarrheal diseases.

To achieve this objective, PSI/Madagascar will target IEC messages to the role of *Sûr'Eau* in maintaining a healthy robust family, which are a source of pride for parents. In an effort to change the perception that *Sûr'Eau* is a product to be used only during cyclones and/or the rainy season, messages will also focus on the importance of consistent year-round use. In addition, IEC materials will show correct dosing and use of the product and will include messages to promote handwashing, latrine building, and good hygiene practices. Messages will be carried via nation-wide television and radio spots, local radio spots translated into the appropriate dialects, and mobile video units that can reach remote areas.

Additionally, funding will be sought to expand the *Hotely Sur'e* program, which recruits roadside restaurants to consistently use and promote *Sûr'Eau (*by giving them technical support and materials, and promoting their establishments in exchange for a contracted commitment to using *Sûr'Eau* for all water and food preparation.) And, the possibility of establishing an equivalent program in schools, called *Sekoly Sur'e*, will be explored.

Output 2

Increased **access** to *Sûr'Eau* water treatment among households nationally, to be measured by:

- % of adults who know where to buy *Sûr'Eau.* [γ]
- % of households that consider *Sûr'Eau* affordable. [γ]
- Increase by 500 the number of retail outlets that sell *Sûr'Eau* each year.
- Increase from 20% to 30% the rural sales points that sell *Sûr'Eau.*
- Increase from 61% to 66% the wholesale outlets servicing retail outlets that sell *Sûr'Eau.*

* Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

[γ] Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

Focusing on the rural areas:

Diarrheal disease takes is greatest toll in rural areas, where, for 58% of households, the water supply is a river, lake, or pond. [46] The prevalence of diarrheal disease in rural areas is around 13%. [47]

In order to bring *Sûr'Eau* to the places where it is needed most, PSI/Madagascar wants to 'piggy back' the product onto the system that it is developing for national subsidized net distribution.

The current 500 mL bottle of *Sûr'Eau* is an inexpensive and effective safe water treatment solution for Madagascar and a PSI distribution survey found that 33% of rural sales points and 53% of those in urban areas have stocked the product. However, the size of the bottle and its weight of 625 grams make the product expensive to transport, particularly for rural retailers and community agents who must often carry the product for long distances. The cost to carry one bottle of *Sûr'Eau* into the rural areas can exceed the 500 Fmg margin that a seller can earn on the bottle, making the current product unprofitable.

PSI/Madagascar is in the process of implementing changes to the current product that will decrease per unit production costs of *Sûr'Eau* including streamlining the instructions on the bottle and removing the additional brochure.

PSI/Madagascar has also submitted a proposal for funding to conduct product research and development of a modified Safe Water Treatment solution. Modifications under consideration in the proposed research and development plan are to reduce the size of the bottle, currently at 500 mL to 125 mL, and to increase the concentration level of the water treatment solution to 1.0 - 2.0%.
Preliminary data from research conducted by the Centers for Disease Control (CDC) and PSI suggest that reducing the size of the bottle and increasing the concentration of the solution have the potential to:

- Reduce the current subsidy.
- Reduce the cost to the consumer.
- Reduce transportation costs for both organizations, as well as commercial and community sales agents.

Testing of this small bottle/higher concentration solution product concept will also inform messages, particularly adapted to rural users, to be developed along with the product. To avoid confusion among the target group in the usage instructions, PSI will work to maintain the same instructions (1 capful for 1 bucket of water) in the new product as in the old. The cap size will change, but not the instructions.

Target groups:

Target groups for *Sûr'Eau* include mothers and fathers aged 20 to 34 in rural and urban areas, of low to medium socio-economic status, with children under five. Mothers continue to be the

[46] INSTAT/DSM/EPM 2001, p. 100.
[47] MICS, 2000.

primary target groups because under 5 year olds are the most vulnerable group[48], and because women are most involved in purchasing health related products in the household, especially inexpensive ones such as *Sûr'Eau.*[49] Fathers were added as a primary target group in 2003 following field research showing that women wanted their husbands to be more involved in and more knowledgeable about preventing diarrheal disease in the home.

PSI proposes to use a modest amount of AIDSMark money to keep minimal operations running (distribution, community based sales, limited promotion, and IEC activities) while long-term resources are found.

AIDSMark support will be used to purchase commodities and develop IEC materials adapted to specific needs of the rural areas, following research results from the new higher concentration/smaller bottle research.

Mobile video units will also continue to do promotional sales and projections of the promo-educational film "*Sûr'Eau Sur'é*". As Madagascar is largely rural, and two-thirds of all youth have no access to mass media (radio, television, press),[50] MVUs bring important health information and branded promotion to rural areas. The maternal and child health communication campaign "Trust and Confidence" includes safe water messages and promotion.

Additional funding sources must be obtained to maintain commodity purchases and national level activities.

Please see Appendix B for a map of *Sûr'Eau* sales for January to September 2003 and Appendix C for annual safe water treatment log frames with sales targets.

IV. INCREASING ACCESS TO SOCIALLY MARKETED HEALTH PRODUCTS IN RURAL AREAS

There are significant challenges to reaching rural populations on a national scale in Madagascar:

- High poverty (Madagascar ranks 149/175 on the Human Development Index[β].)
- Poor infrastructure (In a country of 587,040 square kilometers, there are only 5,781 kilometers of paved roads.)
- Low population density (75/sq mile; 28/sq km)

PSI is committed to extend its existing networks to more fully reach the 77% of the Malagasy population living in rural areas, where health needs are often greatest.

To date, up to 35% of rural sales points have sold socially marketed health products. Additionally, PSI has worked closely with NGOs that have rural networks of community agents to ensure they receive training and materials that prepare them to use, promote and sell

[48] Annuaire des statistiques du secteur de sante de Madagascar, 2000
[49] Focus Groups, PSI 2001.
[50] DHS 1997, p. 27.
[β] *Human Development Report*, 2003

the full range of non-pharmaceutical products (*Protector Plus*, *Sûr'Eau* and *Super Moustiquaire*). The *Mama Super Moustiquaire* program has focused on rural ante-natal clinics in the Tamatave region, and has shown that subsidies can be targeted toward high risk groups in rural areas. And, a pilot project has been developed to establish community based agents for family planning agents in underserved rural areas, through linking them to local sources of supply in the private sector. This project is being implemented with the Peace Corps, who will initially oversee and monitor progress and will be expanded during the project period. An initial formative evaluation of this approach will be conducted in January 2004 to determine modifications needed to ensure success.

To further expand this rural presence PSI will, as promoter and distributor for the national subsidized ITN program, focus intensively on increasing access. To meet the expected five-fold increase in demand, PSI will significantly enlarge its already far-reaching distribution network. IEC messages will be adapted for rural populations and venues for public awareness raising sessions will be expanded to include market days in the commune capitals and assemblies called by local authorities. Health center personnel and district health officials will also be included as key communicators of health messages in rural areas as well as points of sale. This system will be leveraged to include all socially marketed health products.

V. DEVELOPING A REGIONAL APPROACH

Madagascar is a large and diverse country, with over 18 distinct ethnic groups and a larger number of local dialects. PSI will increasingly develop strategies to respond to health issues on a regional rather than national basis through the following means:

- Through the *TOP Réseau* project, PSI will develop new regional offices in Majunga and Fort Dauphin in 2004, to add to the office that was established in Tamatave in 2000 and Diego in 2003. These offices enable a greater degree of coordination among the PSI departments and greater dialogue with local health officials. PSI intends to expand its regional offices to those areas where the *TOP Reseau* project exists.
- These regional offices are supported by a new post (Regional Department Head), based in Antananarivo, and Regional Coordinator, based in each office. Four regional KAP surveys being carried out in CY 2003 into adolescent reproductive health (with finance through the Global Fund) will provide baseline information that will feed into regional communications strategies. Additional baseline KAP surveys will be conducted in the two TOP Reseau expansion sites to ensure that those interventions can be adequately evaluated. Follow-up KAP studies will be conducted in all TOP Reseau intervention sites following a minimum of 2 years of program implementation. These will be supported by the Global Fund and AIDSMark (for the two expansion sites). Regional teams help with the coordination of these studies.
- PSI has the in-house capacity to produce radio spots on a monthly basis, in local dialects that will be responsive to local needs. Participation of the regional offices will be critical to ensuring that regional IEC activities are appropriate to local populations and in making contacts and ensuring coordination with local radio stations.

VI. PARTNERSHIPS WITH THE COMMERICAL PRIVATE SECTOR

One way of improving informed demand for and access to all PSI products is through the work of the Community Based Sales (CBS) department. As a social marketing organization, PSI relies upon the existing network of privately owned, commercial wholesalers and retailers to distribute essential health care products. However, the commercial private sector in Madagascar also includes local businesses and factories that employ thousands of members of PSI's target groups, often in areas of high disease prevalence.

In 2002, PSI began a pilot CBS approach called "Approche aux ONGs et Entreprises" or "APONGE", which focuses its efforts on businesses and NGOs. This approach seeks to expand community based sales to include businesses and factories in every Province, especially in areas of high disease prevalence. In addition, awareness building sessions are planned with the employees of the businesses.

Through the APONGE program, CBS agents provide the following services to businesses:

a) evaluate access to essential health care products
b) conduct worker trainings in health care topics and
c) assure access of PSI products.

To date, more than 100 businesses and organizations have been approached and about 1/3 of those have begun programs.

A good example of the APONGE partnership is the work PSI performs with businesses in Madagascar's tax free zones. These businesses often employ hundreds or even thousands of workers. Each APONGE "consultation" is tailored to the individual needs of the business.

Typical results include

- Improved access to social marketing products such as *Pilplan*, *Confiance* and *Protector Plus* in the company health facility,
- Increased availability of drinking water treated with *Sûr'Eau* for all employees,
- Basic health awareness sessions on STIs, diarrhea and/or malaria for employees, and
- Improved access to ITNs through further company sponsored subsidies or costs amortized over time.
- Training of company health clinicians in modern methods of family planning and the syndromic approach to STI diagnosis.

Increasingly, businesses are also agreeing to free and anonymous distribution of condoms.

Employers see the benefits of a healthy work force on productivity and are eager to continue the partnership. During the next four years, PSI will reinforce these activities by increasing the number of participating businesses and NGOs and by expanding the services provided.

VII. MONITORING AND EVALUATION

PSI will conduct ongoing monitoring and evaluation activities to ensure effective implementation, evidence based strategies, and thus improved project impact on the target groups. The logical framework (Appendix B) outlines the indicators to monitor and evaluate project impact and their means of verification. Monitoring and evaluation activities will include the following:

1. With AIDSMark Funding:

Multi-region Knowledge, Attitude and Practice survey among youth (15-24): In two of the three *TOP Réseau* expansion sites (starting in 2005), KAP surveys will be conducted to serve as baselines for project activities. They will also enable PSI to develop regional communication strategies to address local needs. Baseline will be followed up by a second survey in 2007 to measure progress. The surveys will focus mainly on the areas of STIs (including HIV/AIDS) and unwanted pregnancy. Included in the questionnaire will be filters that identify young women who claim to have accepted gifts or money in exchange for sex (ie informal CSWs) and this will enable PSI to gain some insight into changing behavior among CSWs. For other sites the KAP surveys are supported by resources from the Global Fund (see item 2 below).

Monitoring and evaluation for Top Réseau clinics: A key element of the *TOP Réseau* project is the system for maintaining and monitoring all elements of quality (from service provision, client care to cleanliness and clinic branding). Tools for monitoring quality of care include: a clinic audit tool (eg looking at conformity to branding, availability of IEC materials, clinic cleanliness, presence of appropriate sterilizing equipment); regular supervisory visits from a PSI representative and quarterly re-training sessions that test and reinforce technical knowledge; and mystery client surveys that measure client-provider interaction. The appropriateness of treatment offered is monitored through the MIS system, which records client symptoms, and the prescription issued by the provider as well as mystery client surveys which document the prescribed treatment for the "fictitious" STI presented by the mystery client. KAP surveys also capture change in behavior and attitudes among TOP Réseau clients (see below).

Top Réseau Peer Education monitoring and evaluation: The peer educators are continuously monitored and evaluated by the Peer Educator Supervisor, the BCC/IEC Coordinator, and the *TOP Réseau* Assistant Coordinator. In addition, the peer educators are evaluated by participants attending their presentations on a monthly basis. A certain number of participants are asked by the Peer Educator Supervisor to fill out an anonymous questionnaire that covers the information that they learned in the presentation and their appreciation of the peer educator's presentation. The peer educators are also asked to perform self-evaluations once a month. In addition, the KAP survey provides valuable information regarding exposure to peer education presentations and changes in attitude and behavior. The 2002 KAP will report on this and give valuable information regarding the impact of the peer educator project including presentations and individual contacts as well as the counseling that is provided by *TOP Réseau* providers in the clinics themselves.

Evaluation of effectiveness of Cura7 - structured interviews with prescribers and people with STIs who go to clinics and self-medicate: This quantitative study will be based on work already carried out by PSI in Uganda on the *Clear7* project, and will examine the effectiveness of *Cura7* on treatment outcomes, medication completion rates, partner referrals and subsequent condom use among those who use *Cura7 and those who use another treatment method.* The efficacy of the product will also be tested to ensure that the actual antibiotics are efficacious in treating genital discharge syndrome in Madagascar (rule out the doubt of ineffectiveness due to resistant strains). The AIDSMark project will support this important evaluation.

MVU, Video, and Radio Evaluations: Baseline and follow up KAP studies linked to the Top Reseau project in several regions will supply valuable information needed to evaluate and provide important feedback for the MVU, video, and radio campaigns among the target groups.

Qualitative Research: Qualitative research will include a continuation of pre- testing of all IEC products (radio, video, graphics, etc.) with the appropriate target groups and by region of intervention. Qualitative research regarding the attitudes and behaviors related to STIs and HIV (including condom use barriers, dual protection, and health seeking behaviors) of young men 15- 24 years old will be re-conducted (the last research was done in 1999) to inform and develop the BCC campaigns with this target group.

For *SuperMoustiquaire* and *Sûr'Eau*, PSI is planning to evaluate two training programs conducted for community based agents, with the aim of informing and improving future community-based sales initiatives.

For *PaluStop*, qualitative research will be conducted to assess correct message delivery regarding the product by retailers and pharmacies.

Listening Groups: Listening groups composed of target groups (young men, women of child bearing age) will provide a continuous flow of feed-back for the radio. There are 10 existing listening groups for the radio show "It's my choice", and by the end of 2004 there will be almost 25 in place. These listening groups are run by a trained facilitator who brings together a homogenous group of the same people each week to listen to the radio show. The facilitator has a discussion guide, as well as questionnaires for the participants which will be sent in to the BCC radio production team. The facilitator discerns which messages were understood and which need to be adapted or modified, and communicates this information to the BCC radio production team. For the radio show "Trust and Confidence", 23 listening groups will be re-activated in early 2003 in collaboration with the NGO "Dodwell Trust", and will provide feedback for the shows which treat subjects pertaining to maternal and child health including malaria prevention and treatment, safe water practices and hygiene, and reproductive health issues. The recipients of the audio cassettes (CSWs, truck drivers, and military men) will be asked to give feed-back by filling in questionnaires as a follow-up to the distribution of these cassettes.

2. With funding from other sources:

Multi-region Knowledge, Attitude and Practice survey among youth (15-24): With funds secured separately through the Global Fund, PSI will conduct a baseline KAP survey in four sites in Madagascar in CY 2003, including three new sites where *TOP Réseau* will be established. The survey instrument is the same as the one to be used for the two 2005 expansion sites and will be followed up by a second survey in 2005 to measure progress.

Malaria and Safe Water KAP studies : With funding from the CDC, PSI will conduct KAP surveys in 2004 in 2 of Madagascar's 111 districts to evaluate progress since the introduction of *Mama Super Moustiquaire* in the Tamatave district and one other district. Follow-up KAPs in 2006 in these sites will be funded by the Global Fund. Malaria knowledge and practice indicators, including use of LLITNs, will be the focus of these KAPs. In addition, since target groups are similar, questions regarding knowledge and use of pre-packaged treatment (PPT) for malaria and safe water treatment solution will also be included. PSI recognizes that KAP surveys in only 2 sites will not be as nationally representative sample. However, given the financial and human resources available, these 2 studies will provide an estimation of progress to increasing informed demand for LLITNs, malaria PPT, and safe water treatment. PSI plans to hold a research workshop with senior research advisors from PSI/Washington headquarters in the first trimester of 2004, during which innovative and low-cost methods for monitoring and evaluation will be explored for adaptation to this project. This may change the monitoring and evaluation scope from using the maternal and child health multi-product KAP surveys, to more continuous evaluation tools such as LQAS in conjunction with geographic mapping. Updates will be made to the Monitoring and Evaluation after completion of this workshop.

DHS 2003: PSI/Madagascar has negotiated with the researchers of the DHS 2003 to include relevant questions in this upcoming survey which would help evaluate PSI project impacts and aid in refining communication strategies. This study was originally due to be held in 2002, but was delayed due to the political crisis in that year.

Réseau d'Etude de la Résistance du Paludisme (RER): In collaboration with technicians from the MOH and Institut Pasteur Madagascar's RER, chloroquine's continued effectiveness in treating malaria will be monitored closely.

PaluStop Pharmacovigilance: The MOH-Service Lutte Contre le Paludisme et la Peste, WHO, and IPM, with financing form Project CRESAN 2, are working to establish a network of 12 doctors (2 per province) who will track progress on RBM indicators and will apply a protocol of pharmacovigilance to monitor potential risks of toxicity in children of low weight.

VIII. ORGANIZATIONAL DEVELOPMENT AND DISSEMINATION OF LESSONS LEARNED

A. Strengthening local capacity

To achieve the goals mentioned above PSI must build the capacity of its local staff. Capacity building has always been a priority; PSI has conducted many types of formal and informal training, in classrooms, on the job and abroad. Between 1999 and 2002 PSI sent 40 staff members on training, conferences or international experience sharing visits in more than 10 countries in Africa, Asia and the USA.

Below is a list of key international opportunities attended and planned in 2003:

Employee Position	Purpose	Theme	Place	Date
Coordinator ITN Coordinator Chloroquine	Conference	Global Malaria Prevention and Control, organised by CDC	Uganda	January 2003
Coordinator Medical Promotion Coordinator Contraceptives Coordinator MVU Coordinator IEC Coordinator Safe Water systems	Conference	International conference on Social Marketing (organised by CAMS)	Senegal	April 2003
Chef de Département Régional Coordinator Régional Tamatave	Marketing workshop,	Adolescent Reproductive Health, organised by REDSO	Tanzania	July 2003
Coordinator quantitative research; Research Supervisor	Workshop	Quantitative research methods – organised by REDSO	Uganda	October 2003
Senior Management Team	Conference	PSI Regional Retreat	South Africa	October 2003
Department Head, Pharmaceutical Goods	Workshop	Innovative approaches to communication for HIV/AIDS	Center for Communication Programs; Johns Hopkins University; Baltimore, MD	October-November 2003

At the end of 2003, PSI will organise its annual training for national staff, including commercial agents from all provinces, MVU teams, medical detailers, and Peer Educators.

B. Documentation and Dissemination

Several of PSI/Madagascar's socially marketed products are new initiatives, even for PSI worldwide. PSI regularly devotes time and resources to documentation and dissemination of lessons learned and success stories.

PSI has regularly documented lessons, success stories and promising practices in brief "one-pagers", including *Sûr'Eau*, *TOP Réseau*, the Cinemobile (MVU) program, and a PSI profile on PSI/Madagascar's revitalization of a social marketing program. PSI has also regularly reported on its successes at national and international conferences, and recently presented on *Cura7* and the new PPT Chloroquine therapy at the CAMS conference in Senegal in April 2003.

In May 2003 in Antananarivo and September 2003 in Tamtave, PSI presented to partners the results of the two rounds of ARH KAP surveys (1999 and 2002) conducted in Tamatave as part of the evaluation of the TOP Réseau project (through Gates Foundation funding). These results will contribute to the overall knowledge of ARH in Madagascar, and assist in ARH programming for other partners.

In September 2003, the *PaluStop* coordinator represented PSI at the WHO Technical Consultation on Specifications for pre-packaging anti-malarial Drugs in Geneva.

In October 2003, PSI presented results to partners of its study of target group preferences for condoms. The objective of this study, funded by the *Unité de Gestion de Projet/Projet Multi-sectoriel pour la Prévention du SIDA (UGP/PMPS),* is to inform Ministry of Health and World Bank decisions in procuring and distributing condoms on a nationwide basis. The results of this study will help formulate the order for these condoms, and it is possible that PSI will be asked to distribute these new condoms.

APPENDIX A: 2003 AIDSMark Project Achievements (January to August 2003)

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
1. Reduce HIV/AIDS and STI transmission by increasing availability of and access to condoms in the private sector.	a. Sell and distribute *Protector Plus* condoms	**Benchmark :** Sell 4,550,000 condoms **Achievement :** Total condoms sold and distributed: 7,738,299 (170%)	Sales and distribution figures	Sales Reports from commercial distributors, MIS and PSI Sales Teams
	b. Distribute SM condoms through appropriate points of sale (POS) in urban and rural areas	**Benchmark Annual 2003 :** Increase number of POS for *Protector Plus* by 1,075 (75 wholesale and 1,000 retail) **Achievement January to August 2003 :** Total: 1,352 POS recruited (80 wholesale and 1,272 retail)	Number of new POS selling *Protector Plus* condoms	Sales Reports from project MIS indicating number of new customers, type of POS and location by district and town
	c. Promote condom use and *Protector Plus* condoms by radio, television, and other mass media.	**Benchmark Annual 2003 :** Create 18 new radio spots (11 branded and 7 generic/educational) Produce and air 2-3 times per month; Create and air 4 educational/promotional radio program per month Create BCC cassette tapes for use by truck drivers, army troops and CSW target groups. Air 2 new and 2 old video spots on television and via mobile video units. Produce and air the new television series (4 episodes) with key HIV/AIDS prevention messages. **Achievement January to August 2003 :** 31 new radio spots (13 branded and 18 generic/educational) created (and translated into 8 local dialects), aired more than 11,900 times nationwide 25 educational radio programs created, with 311 airings nationwide.	Target group awareness of *Protector Plus* condoms Target group understanding of condom efficacy Numbers of spots and programs created and aired Number of cassettes distributed to the target groups	IEC Monthly Reports Research Study: Evaluation of Radio Campaign 2002

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
		A total of 11 new video spots produced and aired; 2 new video spots produced locally and aired 818 times, and 3 international Youth Aids spots subtitled in Malagasy and aired 781 times nationwide , including one with Justin Timberlake, two old spots aired. Four episodes of the television series has been completed planed to be aired. 2 editions of the cassette for truck drivers were created and 240 copies distributed to the target group. In focus group studies among both young males and females, key messages retained by the majority included the brand slogan (*"plus fin, plus fort"*, as well as the product's utility against STIs and HIV/AIDS. Around half retained the fact that *Protector Plus* is effective against pregnancy. (Etude Evaluation des Campaigns Radiophoniques Menée par PSI, 2002)		
	d. Promote *Protector Plus* condom wholesalers to retailers/consumers through point of sale materials, media promotion, sponsorships, and community events	**Benchmark:** Increase in number of retailers linked to a wholesaler for the procurement of *Protector Plus* condoms **Achievement:** Preliminary results from the 2002 PSI Distribution Survey show that 65% of wholesalers and 44% of retailers report having sold *Protector Plus* condoms and 53% of wholesalers are currently selling them.	Retailers/ consumers can identify at least one official *Protector Plus* wholesaler in their vicinity	2002 PSI distribution survey
	e. Educate consumers about correct condom use and dispel myths and rumors through radio education, video tools, CSW outreach and MVU performances	**Benchmark:** Increase in number of consumers who report knowing how to use a condom and who are actually using condoms **Achievement**:) *45% of CSWs in Antananarivo and 61% in Tamatave reported having at least once refused sexual relations with a client who refused to wear a condom.* Etude Formative IST /SIDA Octobre 2002	Interviewees are more likely to use condoms if they've heard the program's IEC campaigns. # of CSWs reached	Future KAP Surveys in Tamatave , MVU Evaluation Study,

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
			through outreach program # of MVU performances with condom demonstrations	107 MVU performances with condom demos
	f. Conduct qualitative research concerning *Protector Plus* users and providers.	**Benchmark:** Identification of 1) basic STI/AIDS knowledge, attitude and practice; 2) obstacles to product use; and 3) preferences regarding redesign of packaging **Achievement:** One focus group study conducted (Etude Evaluation des Campagnes Radiophoniques Menée par PSI, 2002) which showed 1) an awareness of the existence of STIs and HIV, however many myths regarding transmission exist and revealed 2) specific barriers to use identified included lack of sensation with condoms, and a perception that they need only be used with 'doubtful' partners, and finally, indicated 3) a low level of consistent condom use	Research study and report finalized	Research results, revised strategy, project budgets
2. Reduce HIV/AIDS and STI transmission by increasing the use of pre-packaged STI therapy among people with STIs	a. Social marketing of PPT kits (Cura7)	**Benchmark:** Sell 59,350 Cura7 kits **Achievement:** 94,162 kits sold (159%)	Sales figures	Sales Reports from pharmaceutical distributor.
3. Reduce HIV/AIDS and STI transmission by increasing the use of pre-packaged STI therapy among people with STIs	Provision of ARH services to youth in the Tamatave area	**Benchmark:** Serve 5,110 young FP and STI services clients **Achievement:** 5,809 young FP and STI services clients served (114%)	Provider data collection	Service MIS
4. Increase family planning CYPs	a. Social marketing of contraceptives (condoms,	**Benchmark:** Sell: 4,550,000 condoms	Family planning CYPs generated by CSM	Sales Reports from commercial

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
generated by SM products	OCs, injectables)	715,000 cycles of pills 243,000 injections Target : 146,333 CYPs* **Achievement**: 7,738,229 condoms sold and distributed (170% of objective) 676,640 cycles of pills (95% of target) 237,414 injections (98% of target) 168,948 CYPs (115% of objective) *CYP conversion factors: condoms 120, OCs 15, injectables 4.	products	distributors and PSI Sales Teams
	b. Distribute contraceptives to appropriate POS	**Benchmark:** Increase the number and geographical range POS for injectables, OCs, and condoms (POS appropriate to product categories). Zone of expansion: Diego, Tulear, and Majunga provinces. **Achievement**: 28 pharmaceutical wholesalers, 202 pharmacies, and 161 dépots de médicaments distributing our products in 6 provinces	Number of POS carrying *Protector Plus*, *Pilplan* and *Confiance*	Sales Reports, retail outlet records
	d. Advertise/promote contraceptives through radio, print, promotion, and community activities	**Benchmark:** Increased consumer awareness of methods/brands **Achievement**: 77%,69% and 57% of young women (15-24) interviewed in a PSI KAP survey in Tamatave indicated awareness of pills, injectables and condoms respectively (May 2001). Results of 2003 follow-up KAP survey will be used to measure progress against these indicators. Knowledge of PSI brands of *Pilplan* and *Confiance* however remains low, due to limitations on branded advertising. (Etude Evaluation des Campagnes Radiophoniques Menée par PSI, 2002)	Consumer awareness and identification of SM brands; consumer use of brands	Sales Reports, Project MIS Reports
	e. Advertise and promote contraceptives through point of sale materials	**Benchmark:** Increased retailer/provider incentive to stock social marketing brands; increased consumer awareness of where to obtain products.	Retailer/provider product stock levels of social marketing	Sales Reports, Distribution Reports

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
		Achievement: Retailer stock of social marketing brands will be determined in Distribution Survey planned for 1st Quarter 2002. 68% of young women knew of a place to obtain pills and 60% knew of a place to obtain injectables (Tamatave KAP 2001). Results of 2003 follow-up KAP survey will be used to measure progress against these indicators. Knowledge of PSI brands of Pills and Injectables however remains low, due to limitations on branded advertising. (Etude Evaluation des Campagnes Radiophoniques Menée par PSI, 2002)	brands; consumer knowledge of social marketing brands	
	f. Conduct Nationwide Distribution Survey for all products	**Benchmark:** Identification of 1) product availability in both traditional and non-traditional outlets for all products, 2) Prices charged 3) Where sales points purchased product **Achievement**: Preliminary results of the 2002 Distribution Survey indicate that *Pilplan* is available in 93% of pharmacies and 81% of depots de medicaments, and *Confiance* is available in 92% of pharmacies and 69% of depots de medicaments	Provide baseline information regarding distribution of all products currently social marketed.	Production of final report
5. Reduce diarrheal disease by increasing the use of home water treatment solution.	a. Social marketing of *Sûr'Eau* water treatment solution	**Benchmark:** Sell 255,900 bottles of *Sûr'Eau* **Achievement:** 323,310 bottles of *Sûr'Eau* sold (126% of objective)	Sales figures	Sales Reports which indicate type of POS and location by district and town
	b. Distribute *Sûr'Eau* through appropriate POS	**Benchmark Annual 2003** Recruit 1,100 new POS (100 wholesale and 1,000 retail outlets). **Achievement January to August 2003** 1,410 new POS recruited (175 wholesale and 1, 235 retail outlets) - 128% of objectives.	Number of new POS selling *Sûr'Eau* water treatment solution.	Sales Reports which indicate type of POS and location by district and town
	c. Promote the use of *Sûr'Eau* and safe water	**Benchmark annual 2003** ▪ Create 20 new radio spots (11 branded and 9	Consumer awareness of *Sûr'Eau* water	IEC, MVU Monthly Reports

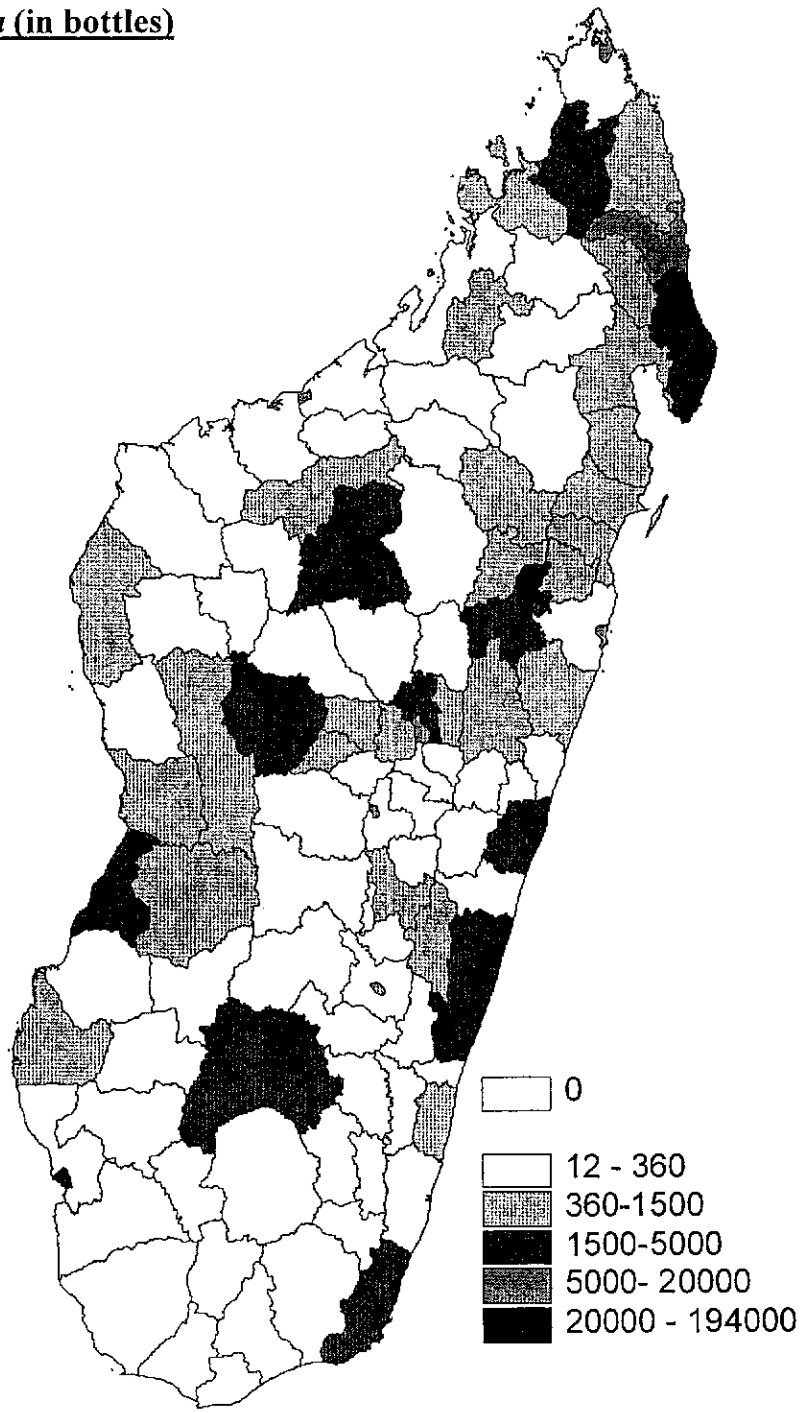
RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
	through radio, television, MVU, and other mass media.	generic/educational) and aired 14,000 times. ▪ Produce 42 and air 336 times an educational/ promotional radio program (with *Super Moustiquaire* and *Protector Plus*). ▪ Create new song and video clip ▪ Create 4 new video spot and air 360 times all existing spots. ▪ 240 projections/animations, 28 events and 480 flash sales must be realized for the MVU team for *Sûr'Eau* for 120,000 people to reach. **Achievement January to August 2003** ▪ Produced 17 new radio spots (10 branded and 7 generic/educational) and existing spots were aired 8,887 times. ▪ Produced 4 and aired 47 times per month an educational/promotional radio program (with *Super Moustiquaire* and *Protector Plus*). ▪ A new song with the famous singer BODO and a video clip were created. ▪ Produced 4 new video spot and aired 224 times (with 2 existing spots). ▪ 143 projections/animations, 12 events, and 222 304 flash sales were realized by the MVU team for *Sûr'Eau* for 321,220 people reached.	treatment. # of radio spots produced and aired # of MVU performances # of video spots produced and aired	
	d. Promote *Sûr'Eau* wholesalers to retailers, and restaurant owners through point of sale materials, media promotion, sponsorships, and community events	**Benchmark Annual 2003** ▪ Increase number of retailers linked to wholesalers for the procurement of *Sûr'Eau.* ▪ Increase the number of retailers a wholesalers who know *Sûr'Eau.* ▪ Increase number of retailers a wholesalers who sell *Sûr'Eau* - Recruit 1,100 new POS (100 wholesale and 1,000 retail outlets). ▪ Recruit and certify Hotely Sur'e to use and promote *Sûr'Eau* on a consistent basis in their restaurant.	% retailers and wholesalers who know, have sold, sold currently *Sûr'Eau.* # *Hotely Sur'e* Retailers, consumers, restaurant owners can identify at least one official *Sûr'Eau* wholesaler in their	2002 PSI Distribution Survey Etude sur Motivation d'Achat de *Sûr'Eau*, 2002

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
		Achievement January to August 2003 ▪ The PSI Distribution Survey in 2002 shows that : • 95.6% of POS (100% for wholesalers, 95.9% retailers) know *Sûr'Eau.* • 43.27% of POS (78.3% for wholesalers, 35.9% retailers) report having sold *Sûr'Eau.* • 37,4% of POS (61.7% for wholesalers, 21.8% retailers) currently sell *Sûr'Eau.* • 64% of the POS are supplied by PSI and 34,1% get stock from the wholesalers ▪ 1,410 new POS recruited (175 wholesale and 1, 235 retail outlets) - 128% of objectives. ▪ 96% of urban households recognize the brand *Sûr'Eau* 18% of Malagasy households have used *Sûr'Eau* at least once, and 9% report being regular users (PSI KAP study, November 2001). ▪ 217 *Hotely Sur'e* are currently in place. In PSI's "Etude de motivation d'achat" in March 2002 women stated that they preferred to eat at *Hotely Sur'e* certified restaurants because the felt reassured of the quality of the hygiene there.	vicinity	
	e. Educate consumers about the benefits of safe water on a consistent year-round basis through radio, video and MVU communication.	**Benchmark Annual 2003** • Increase in number of consumers who report using *Sûr'Eau.* • Plan 168 formations of special groups of mother (with *Protector Plus*) for 3,360 people, 24 formations of intermediate commercial for 480 people and 120 sensitizations for employers of society. • 240 projections/animations, 28 events and 480 flash sales must be realized for the MVU team for *Sûr'Eau* for 120,000 people to reach. **Achievement January to August 2003** • 1,406,306 bottles sold since March 2000, increase of 124% in relation to the yearly sales of 2002 (256,432 bottles). • 71 formations of special groups of mother (with *Protector Plus*) for 1,492 people, 7 formations of intermediate	Interviewees are more likely to use *Sûr'Eau* if they've heard the program's IEC campaigns and have personal contact with current users.. Number of bottle sold Number of MVU performances Number of radio programs	Sales Reports from commercial distributors and PSI Sales Teams.

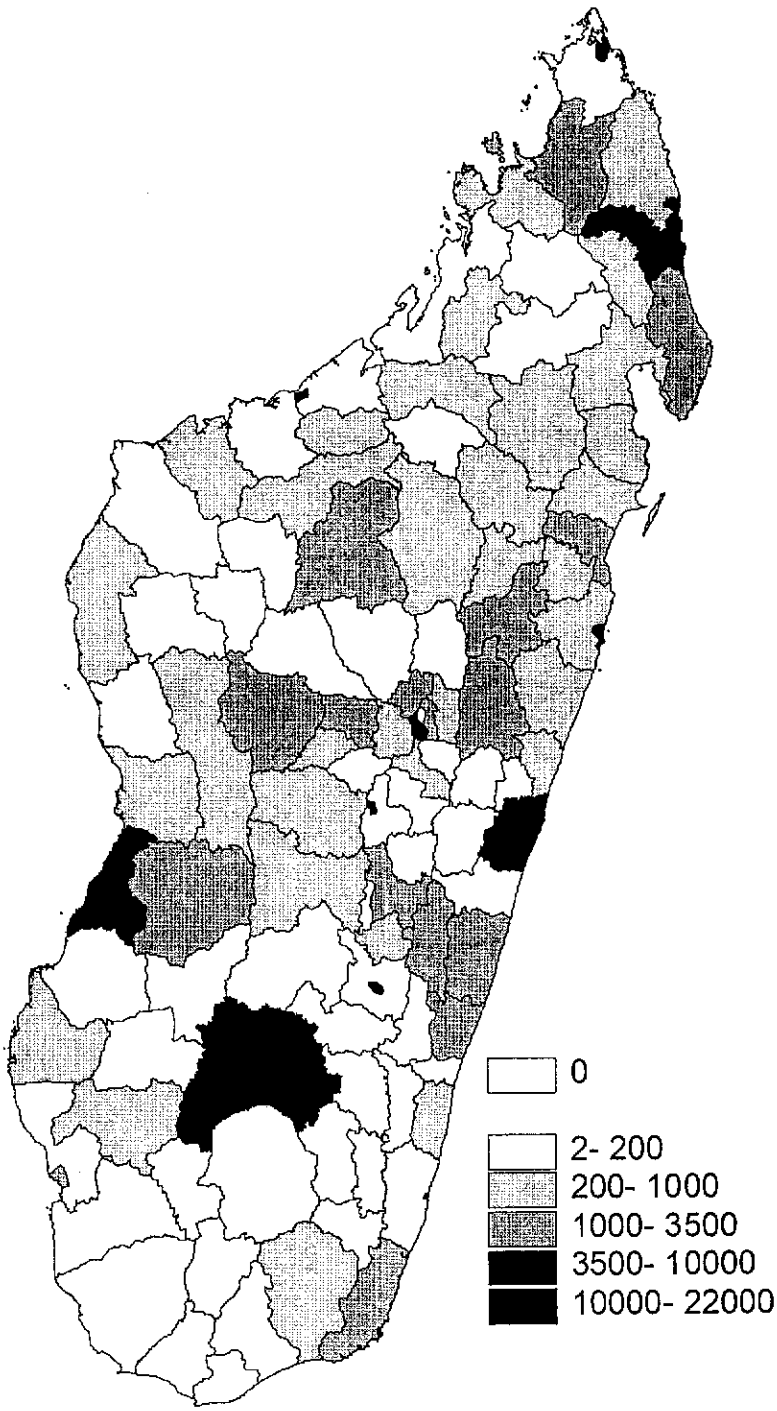
RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
		commercial for 133 people and 24 sensitizations for employers of society. • 143 projections/animations, 12 events, and 222 304 flash sales were realized by the MVU team for *Sûr'Eau* for 321,220 people • 96% of urban households recognize the brand *Sûr'Eau* 18% of Malagasy households have used *Sûr'Eau* at least once, and 9% report being regular users (PSI KAP study, November 2001). • However, people have a positive perception of those who use *Sûr'Eau* and new users state that the influence of current users coupled with advertising encouraged them to buy *Sûr'Eau*. (Etude de motivation de l'achat, March 2002).	Number of radio spots	
6. Reduce malaria morbidity and mortality by increasing the use of long-lasting insecticide-treated mosquito nets (LLITNs) among children under five and pregnant women throughout Madagascar	a. Social marketing of *SuperMoustiquaire* (LLITNs)	**Benchmark:** Sell 91,404 *SuperMoustiquaire* (rectangular and conical and *Mama SuperMoustiquaire* LLITNs) **Achievement :** 68,661 *SuperMoustiquaire* -- sold (75% of objective)* ** To prepare for the transition to national program of subsidized nets, PSI has undergone planned "stock-outs" to empty the commercial pipeline of cost-recovery nets. This has interrupted sales temporarily, but annual sales objectives are expected to be met.*	Sales figures and sales figures from health centers	Sales Reports from commercial distributors and PSI Sales Teams; sales
	b. Distribute *SuperMoustiquaire* through appropriate POS	**Benchmark, 2003 Annual:** Recruit 80 new wholesalers and 1,065 new retail sales points **Achievement January to August 2003 :** 89 new wholesalers recruited, and 280 new retailers recruited.	Number of new POS selling *SuperMoustiquaire LLITNs.*	Sales Reports from project MIS
	c. Promote consistent ITN usage and *SuperMoustiquaire* by	**Benchmark, 2003 Annual:** Create and air 16 new promotional and educational radio spots. Create 4 educational program and air 2-4 times per month (with *Sûr'Eau* and *Protector Plus*)	Consumer awareness of SM LLITNs	IEC Monthly Reports

RESULTS	ACTIVITIES	BENCHMARKS/ACHIEVEMENTS	INDICATORS	DATA SOURCES
	radio, television, MVU, and other mass media.	Broadcast *SuperMoustiquaire* TV spot. Produce 2 new TV spots to be aired by end 2003. Distribute and air *SuperMoustiquaire* film and music video on TV stations and via mobile video units. **Achievement January to August 2003 :** Produced and aired nationwide 9 promotional and 7 educational radio spots as well as 8 educational/promotional radio programs. Broadcasted nationwide the promotional TV spot 233 times; the *SuperMoustiquaire* movie and music video were aired on Africa Malaria Day 142 MVU animations with movie projections and 286 promo sales events	# radio spots produced and aired # video spots produced and aired # MVU performances	Evaluation of radio campaign
	d. Promote *SuperMoustiquaire* wholesalers to retailers, consumers, and restaurant owners through point of sale materials, media promotion, sponsorships, and community events	**Benchmark :** Increase in number of sales points. **Achievement :** In Tamatave II, only 8% of respondents said they know where to buy a treated mosquito net (pre-launch of *SuperMoustiquaire*). (PSI/KAP 2001). *SuperMoustiquaire* is now available in about 3,000 sales points nationwide. Community based sales have also begun. However, rural penetration is low, and there is a low perception of availability by the target group. In a 2002 PSI distribution survey, preliminary results show that 41% of wholesalers reported having sold *SuperMoustiquaire* , with 35% currently selling.	Retailers and consumers can identify at least one official *SuperMoustiquaire* wholesaler in their vicinity	Interviews with retailers and consumers 2002 PSI distribution survey Distribution reports

Appendix B.
Sales of *Sûr'Eau* (in bottles)
Jan-Sept 2003



Appendix B.
Sales of *SuperMoustiquaire*
Jan-Sept 2003



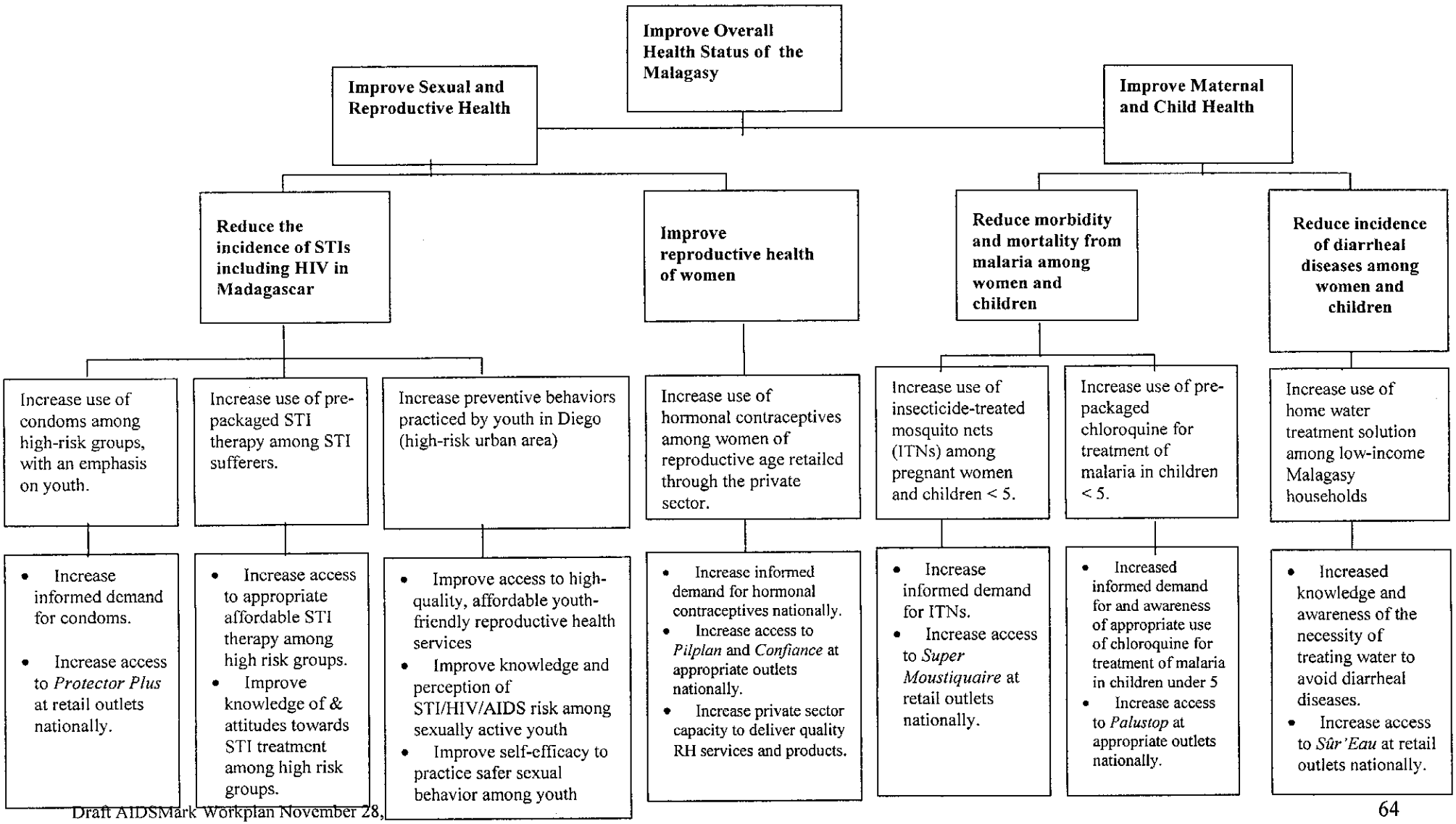
Appendix B.
Sales of *PROTECTOR Plus* (in units)
Jan-Sept 2003

Summary of Districts with sales > 100,000 in 2002

District	Code	Sales of *Protector Plus*
Antananarivo-ville	101	1,680,720
Toamasina-ville	501	402,000
Mahajanga-ville	401	365,280
Antsiranana-ville	201	273,072
Fianarantsoa-ville	301	236,256
Antsirabe-ville	110	198,144
Toliara-ville	601	193,392
Ihosy	313	149,184
Antananarivo-sud	102	119,040

APPENDIX C: Project Logframes

PSI/MADAGASCAR SOCIAL MARKETING PROJECT



PSI/Madagascar Condom Social Marketing Logframe (October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Reduce the incidence of STIs including HIV in Madagascar	1. Decrease in prevalence of STIs including HIV.	The project will not be measured at this level.	Political and economic situation does not deteriorate
Purpose Later onset of sexual activity, decrease in number of sexual partners, and increased use of condoms among high-risk groups, with an emphasis on youth.	1. Sale of condoms (with particular focus on 20 high risk zones) : 2004 : 7,700,000 2005: 8,470,000 2006: 9,317,000 2007: 10,248,700 2. Sale of condoms to people with STIs : 2004: 1,365,000 2005: 1,638,000 2006: 1,916,460 2007: 2,203,929 3. Condoms distributed free in Educational Brochures : 2004: 770,000 2005: 847,000 2006: 931,700 2007: 1,024,870 4. Condoms distributed free to public sector *: 2004: 2,660,000 2005: 700,000 5. Decreased median age at which youth begin sexual activity ϒ 6. Decreased % of 15-24 year olds who report that they hade more than one sexual partner in the last year. ϒ 7. Increase in % of 15-24 year old males reporting condom use in last sex act with a) regular partner b) occasional partner, c) commercial partner. ϒ 8. Increase in the % of sexually active 15-24 year olds reporting condom use in "most cases: or "always" with a) regular partners, b) occasional partners, and c) commercial partner. ϒ	1-4. PSI Monthly Sales Reports 5-8. 2003 & 2005 & 2007 Youth KAP surveys	Continued government and international community commitment to improving the health of Malagasy. Condoms are used consistently and correctly.
Outputs 1. Increase informed demand for condoms. 2. Increase access to *Protector Plus* condoms at retail outlets nationally.	1.1 Increase in % 15-24 year olds who are aware that a person's STI and HIV status cannot be determined by looking at the person ϒ. 1.2 Increase in % 15-24 year olds who know that consistent condom use is an effective means of preventing STI/HIV/AIDS transmission.ϒ 2.1 Increase by 500 each year in number of retail outlets that sell *Protector Plus* 2.2 Increase in % of bars and nightclubs that sell Protector Plus from 44% to 50%. 2.3 Increase from 28.5% to 33.5% of outlets in rural areas that sell Protector Plus. 2.4 Increase from 53% to 63% of wholesale outlets servicing retail outlets that sell Protector Plus. 2.5 Assure that less than 5% of urban youth in Top Réseau project areas think that condoms are difficult to find.	1.1-1.2 2003 & 2005 Youth KAP surveys 2.1 – 2.4 Project MIS; 2002 and 2006 Distribution surveys 2.5 2003 & 2005 Youth Survey KAP	Project partners able to carry out effective activities. Communities actively participate in and support intervention activities. Targeted wholesalers and retailers amenable to stocking and selling *Protector Plus* condoms.

* These estimates represent public sector orders confirmed. Future orders may be supplied by PSI or by the World Bank.
ϒ Baseline and target indicators to be determined when 2003 KAP data have been collected and analyzed. An update of these indicator percentage values will be supplied to USAID in 2004, when they become available. KAP surveys will be conducted in 4 of Madagascar's 111 districts.

Activities 1.1 Conduct brand advertising campaign for *Protector Plus* through radio, special events, and promotions in collaboration with partners. 1.2 Conduct radio and TV campaigns targeted at young men. 1.3 Conduct interpersonal communication activities targeted at CSWs, and expand CSW peer education program. 1.4 Produce and distribute audio series and the informational "Gazety" targeted at CSWs. 1.5 Produce and distribute audio series targeted at truck drivers and military men. 1.6 Conduct MVU performances and interpersonal communication activities among young men, CSW clients, truck drivers, taxi drivers, military men and miners. 2.1 Monitor and provide training to sales staff. 2.2 Run a sales promotion at wholesale level and at retail level 2.3 Recruit 2,000 new retailers during the project period. 2.4 Conduct sales visits at night to non-traditional points of sale such as hotels and restaurants			

PSI/Madagascar STI Case Management Logframe
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Reduce the incidence of STIs including HIV in Madagascar.	Decrease in prevalence of STIs, including HIV.	The project will not be measured at this level.	Political and economic situation does not deteriorate
Purpose Increase use of pre-packaged STI therapy among STI sufferers.	Generation of 53,235 CYPs [51]ale of PPT kits by year as follows (Cura7 and Genicure Combined): 2004: 195,000 2005: 214,500 2006: 235,950 2007: 259,545	1. Project MIS	Sales objectives based on plan to sell kits in the private sector only. PSI continues to provide technical assistance to the public sector, as well as generic condoms for the public sector PPT kits. Generic condom distribution through this channel is included in all condom distribution figures.
Outputs 1. Increase access to appropriate affordable STI therapy among high risk groups. 2. Improve knowledge of and attitudes towards STI treatment among high risk groups.	1.1 Branded PPT kits sold in 300 urban and rural outlets by end of project. 1.2 90% of urban pharmacies stock STI kits. 1.3 75% of TOP Réseau service providers correctly diagnose and prescribe correct treatment to clients presenting selected syndromes 1.4 1200 service providers trained in correct STI diagnosis and treatment 1.5 Increased % of youth who think that STI medications are affordable 2.1 Increased % of youth who have heard of Cura7 2.2 Increased % of those who have heard of Cura7 that know at least one STI it treats 2.3 Increased % of youth who have heard of Genicure 2.4 Increased % of youth who have heard of Genicure that know at lease one STI it treats	1.1 Project MIS. 1.2 Mystery client surveys 1.3 Training logs 2. 2004 and 2006 KAP studies*	Political situation permits sustained and effective PPT promotion and training
Activities 1.1 Expand private distribution network 1.2 Train 300 to 400 private sector doctors annually in syndromic approach to STI management 1.3 Recruit 3 wholesale pharmacists and 15 NGOs to dispense directly to their clients 1.4 Establish referrals for PPT kits in 90% of private sector pharmacies. 2.1 Promote STI PPT kits in professional medical and pharmaceutical journals. 2.2 Develop visual aids describing benefits of STI PPT for prescribers and dispensers 2.3 Informational visits to prescribers and dispensers. 2.4 Produce and place articles in the print media targeting CSW clients 2.5 Produce and place educational stickers, educational posters, and articles in youth magazines. 2.6 Produce and broadcast 3 generic TV and radio spots. 2.7 Implement peer education activities among young men (with TOP Reseau) and CSWs 2.8 Produce and distribute Le Mensuel, a monthly informational newsletter, among health providers.			

*** KAP baselines and targets by site will be determined after analysis of the results of the 2004 Youth KAPs**

[51] CYP factor used: one CYP for every 17 kits (based on a factor of 120 condoms per CYP)

PSI/Madagascar Franchised RH Services for Adolescents (*TOP Réseau*) Logframe
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Reduce the incidence of STIs including HIV in Madagascar	Decrease in prevalence of STIs and maintenance of current low HIV prevalence.	The project will not be measured at this level.	Political and economic situation does not deteriorate
Purpose Increase preventive behaviors practiced by sexually active unmarried youth in Diego	1. Increase % of 15-24 year old males reporting condom use in last sex act with a) regular partner from and b) occasional partner.* 2. Increase in the % of sexually active 15-24 year old reporting condom use in "most cases: or "always" with a) regular partners, and b) occasional partners.* 3. Increase number of male/female clients aged 15-24, experiencing STI symptoms, seen for STI diagnosis or prescription at *TOP Réseau* clinics by 10% annually 4. Increase % of all STI clients aged 15-24 seen at *TOP Réseau* clinics who were referred by their partner.	1-3 2004 and 2006 Youth KAPs* 4-5 MIS Reports from TOP Réseau clinics	Community leaders and parents support program objectives/activities including condom promotion.
Outputs 1. Improved access to high-quality, affordable youth friendly reproductive health services 2. Improved knowledge and perception of STI/HIV/AIDS risk among sexually active youth 3. Improved self-efficacy to practice safer sexual behavior among youth	1.1 Increase in % of 15-24 year olds reporting that they can identify a facility where they can receive STI services 1.2 Increase in % of 15-24 year olds who believe STI treatment services are affordable 1.3 At least 101,920 clients served within the project period as follows (Diego is 100% supported by AIDSMark. Antananarivo, Fort Dauphin, Majunga, and Tamatave are marginally supported by AIDS Mark: 2004: Diego: 2000 Other Towns: 17,000 2005: Diego: 3300 Other Towns: 22,500 2006: Diego: 3630 Other Towns: 24,000 2007: Diego: 3990 Other Towns: 25,500 2.1 Increase % of 15-24 year olds who can identify two or more STI symptoms among males. 2.2 Increase % of sexually active 15- 24 year olds who think they would be at medium/high risk for HIV/AIDS if they did not consistently use a condom 2.3 Increase in % of 15-24 year olds who recognize that they can reduce their risk of STIs if they have one or very few partners 2.4 Increase in % of 15 - 24 year olds who cite that condoms offer the dual benefits of protection against unwanted pregnancy and infection from STIs 3.1 Decreased median age at which youth begin sexual activity 3.2 Decreased percentage of 15-24 year olds who report that they hade more than one sexual partner in the last year. 3.3 Increase in % of 15-24 year olds who report talking with a friend about STIs in the past 12 months 3.4 Increase % of females 15-24 who report they can convince their regular partner to use condoms	1-3 2004 and 2006 Youth KAPs* 1.3 MIS system	Private providers and pharmacies are willing to participate in the training activities. Awareness and acceptance by service providers will translate into usage by consumers.

Activities Launch *TOP Réseau* in Diego Brand 10 new *TOP Réseau* clinic sites Conduct initial training of participating providers 1.4 Implement branded mass media campaign (TV, radio, posters, MVUs) 2.1 Implement mass media and interpersonal communication campaign to raise awareness of HIV, other STIs and condom use as a method for preventing transmission 3.1 Recruit 10 new youth peer educators for Diego and implement youth peer education programs at all sites	

- **KAP baselines and targets by site will be determined after analysis of the results of the 2004 Youth KAPs**

PSI/Madagascar Family Planning Social Marketing Logframe
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Improve reproductive health of Malagasy Women	1. Decreased maternal mortality rate 2. Decreased fertility rate/Increased contraceptive prevalence rate	The project will not be measured at this level.	Political and economic situation does not deteriorate
Purpose Increase use of hormonal contraceptives among women of reproductive age retailed through the private sector.	1. Generation of at least 799,799 CYP[52]s through annual sales of hormonal contraceptives as follows: Pilplan: 2004: 1,100,000 2005: 1,210,000 2006: 1,331,000 2007: 1,464,100 Confiance: 2004: 396,000 2005: 435,600 2006: 479,160 2007: 527,076 2. Increase in the number of hormonal contraceptive users.	1. Sales Reports 2. DHS 2003 Survey	Continued government and international community commitment to improving the reproductive health of Malagasy.
Outputs 1. Increase informed demand for hormonal contraceptives nationally. 2. Increase **access** to *Pilplan* oral contraceptives and *Confiance* injectable contraceptives in appropriate retail outlets nationally. 3. Increase private sector capacity to deliver quality reproductive health services and products.	1.1 Increase in *Pilplan and Confiance* brand awareness and acceptance among urban pharmacists and rural depots de medicaments owners. 1.2 Increase in *Confiance* and *Pilplan* awareness and acceptance among service providers, including nurses and midwives. 1.3 Increase in *injectable contraception* and *oral contraception* awareness and acceptance among specific groups of young women 15 to 24 years of age. 2.1 Increase in number of depots de medicaments that stock *Pilplan*, and *Confiance* 2.2 Increase in % of outlets that sell at recommended retail price. 3.1 Increase in number of *TOP Réseau* providers who correctly counsel new young FP clients about side effects of oral and injectable contraceptives. 3.2 1200 providers and pharmacists trained in PF methods	1.1 – 1.3 Distribution survey , 1.2 Mystery client survey/exit interviews 1.3 Youth KAP surveys 2004 and 2006* 2.1 – 2.2 Distribution report and survey, Sales Reports 3.1 Mystery client surveys 3.2. Training records	Private providers and pharmacies are willing to participate in the training activities. Awareness and acceptance by service providers will translate into usage by consumers. Pharmacies and depots de medicaments are willing and able to stock *Pilplan and Confiance* contraceptives.

[52] CYP factors used: injectable: 4/CYP; pill: 15/CYP. Note that a further 355,577 CYPs will be generated by condom distribution (using a factor of 120/CYP).

Activities Implement generic behavior change campaign for hormonal contraceptives and condoms through mass media and community activities. 1.1 Advertise and promote *SM contraceptive* products through point of sale material. 1.2 Broadcast the new-format "Toky Sy Antoka" family planning radio talk show. 1.3 Advocate legislative change to allow branded advertising for hormonal contraceptives 1.4 Continued TV broadcast and MVU screenings of 4-part soap opera. 2.1 Deploy medical detailing team to provide product support and information to service providers 2.2 Develop and distribute new IEC materials to participating sales outlets 2.3 Explore new avenues for distribution 2.4 Collaborate with Peace Corps to carry out community-based sales 3.1 Provide training for pharmacists and clinical providers on *SM contraceptive* products. 3.2 Conduct continuing professional education lectures among providers 3.3 Conduct mystery client surveys and pre- and post-training tests to monitor quality of trainings.	

***KAP baselines and targets by site will be determined after analysis of the results of the 2004 Youth KAPs**

PSI/Madagascar ITN Social Marketing Logframe
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Reduce morbidity and mortality from malaria among women and children	The program will not be evaluated at this level.		Impact on all-cause mortality and morbidity from increased use of ITNs is as suggested by the Cochrane review
Purpose Increase use of insecticide-treated mosquito nets (ITNs) among pregnant women and children under 5.	1. Sale of ITNs by year * as follows: 2004: 504,000 2005: 565,000 2006: 621,500 2007: 670,000 2. Increase in % of households with at least 1 treated net.[γ] 3. Increase % of target groups sleeping under a treated net last night [γ].	1. Sales reports 2-3 2004 & 2006 KAP surveys	Subsidized program for *Super Moustiquaire* will continue through end 2005, after time the subsidy will end or be phased out. Mosquito nuisances and biting habits do not change.
Outputs 1. Increase informed demand for ITNs. 2. Increase access to *Super Moustiquaire* at points of sale (POS) nationally.	1.1 Increase in % of adults who know malaria is transmitted only through mosquitoes.[γ] 1.2 Increase in % of adults who know malaria is most dangerous for pregnant women and children under 5 .[γ] 1.3 Increase in % of adults who cite mosquito nets as a way to prevent malaria transmission.[γ] 2.1 Increase in % of adults who know where to buy ITNs.[γ] 2.2 Increase in % of households that consider ITNs affordable.[γ] 2.3 Increase by 500 the number of POS that sell *SuperMoustiquaire* each year. 2.5 Increase from 1.5% to 20% the number of rural sales points that sell *SuperMoustiquaire.* 2.5 Increase from 30% to 40% of wholesale outlets servicing retail outlets that sell *SuperMoustiquaire.*	1.1-2.2 and 2.6 2004 & 2006 KAP surveys. 2.3-2.5 Project MIS; 2002 and 2006 Distribution surveys	Socio-cultural barriers to ITN use are overcome by knowledge of and access to ITNs. MOH supports collaboration in malaria control activities. Consumer buying power remains unchanged.

* These estimates are dependent on continuation of national program of subsidized net distribution and continued provision of these nets by other donors.

[γ] Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

Activities 1.1 Reinforce BCC campaign 1.2 Continue media and MVU activities 1.3 Design training materials and curricula with partners 1.4 Conduct targeted community based interventions for high-risk groups 2.1 Implement national strategy to distribute and promote subsidized ITNs 2.2 Expand distribution network to meet expected increase in demand 2.3 Identify new sales outlets and health centers 2.4 Develop community-based sales program and train community-based agents to sell ITNs 2.5 Track Sales and distribution 2.6 Recruit national -level wholesaler and retailers in the private sector. 2.7 Explore the possibility of local manufacture of ITNs.	MoH, community groups, and NGOs are willing to participate in the project.

Social Marketing of Pre-Packaged Chloroquine for Malaria Treatment
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal: Reduced mortality and morbidity from malaria among Malagasy children under 5.	The program will not be evaluated at this level.		
Purpose: Increased use of pre-packaged chloroquine among children under 5 throughout Madagascar.	Sale of malaria PPT by year as follows : 2004: 300,000 2005: 360,000 2006: 432,000 2007: 518,400 1.2 Increase % of target group who report using PaluStop during last case of malaria for their under five year old.. [γ]	Sales reports	Chloroquine is an effective treatment for malaria in Madagascar.
Output 1: Increased informed demand for and awareness of appropriate use of chloroquine for treatment of malaria in children under 5 Output 2: Increase access to *PaluStop* at appropriate outlets nationally.	1.1 Increase in % of parents who correctly cite three symptoms of malaria. [γ] 1.2 % of parents who cite product brand name as an effective malaria treatment for children under 5. [γ] 1.3 % of pharmacists/vendors who correctly cite recommended instructions of pre-packaged chloroquine for children under five 2.1 % of adults who know where to buy pre-packaged chloroquine. [γ] 2.2 % of households that consider pre-packaged chloroquine affordable. [γ] 2.3 Increase by 500 the number of POS that sell *PaluStop* each year[β]. 2.4 Increase number of POS in rural areas that sell *PaluStop*[β] . 2.5 Increase in percentage of wholesale outlets servicing retail outlets that sell *PaluStop*[β] .	1.1-1.2 2004 & 2006 KAP surveys 1.3 Distribution survey 2006 2.1-2.2 2004 & 2006 KAP surveys 2.3-2.5 Project MIS; 2002 and 2006 Distribution survey	Pre-packaged chloroquine can be sold without a prescription. MoH, community groups, and NGOs support and are willing to participate in the project. Funding will be available to conduct a representative follow-up KAP.
Activities Output 1 1.1 Conduct baseline KAP 1.2 Develop, pretest and produce integrated A&P campaigns			

[β] Estimates based on sale of *PaluStop* in commercial sector.
[γ] Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will beconducted in 2 of Madagascar's 111 districts.

1.3 Develop IEC materials in conjunction with partners 1.4 Conduct focus group discussions 1.5 Design training materials for health agents, pharmacists and retailers 1.6 Conduct training of trainers for communication required for selling 1.7 Develop media plan 1.8 Conduct product launches 1.9 Implement radio activities 1.10Conduct final KAP (after Y2) Output 2 2.1 Conduct retail survey to estimate chloroquine market 2.2 Procure chloroquine 2.3 Develop brand for product packaging, IEC 2.4 Identify wholesalers in each provincial capital 2.5 Identify new sales outlets and health centres 2.6 Track sales and distribution 2.7 Conduct follow-up retail survey		

Social Marketing of Home Water Treatment for Diarrhea Prevention in Madagascar
(October 1, 2003 – September 29, 2007)

NARRATIVE	INDICATORS	VERIFICATION	ASSUMPTIONS
Goal Reduce diarrheal disease in Madagascar, especially among children under five.	Program not to be evaluated at goal level due to technical and financial constraints		Continued GOM support for project
Purpose Increase use of home water treatment solution among low-income Malagasy households	1.1 Sale of safe water solution by year as follows : 2004: 483,000 bottles sold 2005: 531,300 bottles sold 2006: 557,865 bottles sold 1.2 Increase % of target group who report using *Sûr'Eau* in the past month. [Y]	1. Sales reports	Pilot testing of lower cost bottle options with consumers is successful
Outputs 1. Increased knowledge and awareness of the necessity of treating water to avoid diarrheal diseases. 2. Increase access to *Sûr'Eau* at retail outlets nationally.	1.1. Increase in % of target group who cite contaminated/dirty water as one cause of diarrhea.[Y] 1.2. Increase in % of target group who cite *Sûr'Eau* as a way to purify water and prevent diarrheal diseases.[Y] 2.1. % of adults who know where to buy *Sûr'Eau.* [Y] 2.2. % of households that consider *Sûr'Eau* affordable.[Y] 2.3. Increase by 500 the number of retail outlets that sell *Sûr'Eau* each year. 2.4. Increase from 20% to 30% the rural sales points that sell *Sûr'Eau.* 2.5 Increase from 61% to 66% the wholesale outlets servicing retail outlets that sell *Sûr'Eau.* 2.6 Decrease in percent of target group who report that safe water treatment solution is difficult to find.	1.1-2.2 2004 & 2006 KAP surveys 2.3-2.6 Project MIS; 2002 and 2006 Distribution surveys	Distribution of *Sûr'Eau* largely influenced by rainy, cyclone and cholera season severity Reticence to trying something new (such as home water treatment) can be overcome using IEC campaigns.

[Y] Baseline and target indicators to be determined when 2004 KAP data have been collected and analyzed. KAP surveys will be conducted in 2 of Madagascar's 111 districts.

Activities 1.1 Produce IEC materials to emphasize consistent year-round use and show correct dosing and use 1.2 Disseminate IEC messages via television and radio spots and MVUs. 2.1 Identify ways to decrease per unit cost of *Sûr'Eau* 2.2 Maintain distribution operations and include *Sûr'Eau* in rural expansion networks of ITNs. 2.3 Track sales and distribution	Partnerships reinforced with other NGOs and CBS agents recruited.

SUMMARY BUDGET

DESCRIPTION	YEAR 1 2004	YEAR 2 2005	YEAR 3 2006	YEAR 4 2007	TOTAL Cost	HIV/AIDS				Family Planning	Malaria	Diarrheal Diseases
						TOTAL HIV/AIDS	*Protector plus*	*Top Reseau*	*Cura7*	*Pilplan/ Confiance*	*SuperM/ Palustop*	*SurEau*
I. INTERNATIONAL STAFF	$98,745	$99,587	$104,567	$109,795	$412,694	$330,155	$247,616	$41,269	$41,269	$41,269	$41,269	$0
II. FIELD STAFF	$441,162	$463,221	$486,388	$510,698	$1,901,469	$1,351,424	$822,419	$271,187	$257,817	$276,229	$242,783	$31,033
III. FRINGES	$216,959	$225,551	$236,132	$247,234	$925,876	$677,041	$436,101	$122,977	$117,963	$124,868	$112,326	$11,637
IV. TAXABLE BENEFITS	$31,360	$49,314	$34,348	$36,006	$151,028	$120,823	$90,617	$15,103	$15,103	$15,103	$15,103	$0
V. TRAVEL	$395,978	$417,736	$436,416	$455,921	$1,706,051	$1,364,840	$1,023,630	$170,605	$170,605	$170,605	$170,605	$0
VI. CONSULTANTS/PROFESSIONAL SERVICES	$50,000	$52,500	$33,076	$34,728	$170,304	$136,243	$102,182	$17,030	$17,030	$17,030	$17,030	$0
VII. FURNITURE/EQUIPMENT	$55,800	$50,295	$21,940	$23,037	$151,072	$121,029	$75,780	$32,790	$12,459	$17,584	$12,459	$0
VIII. COMMODITIES	$103,200	$108,360	$113,778	$0	$325,338	$0	$0	$0	$0	$0	$0	$325,338
XI. PACKAGING	$148,998	$181,974	$203,027	$220,332	$754,332	$435,955	$326,058	$0	$109,897	$318,377	$0	$0
XII. SUBAWARDS/SUBCONTRACTS	$97,010	$112,047	$129,414	$149,473	$487,944	$155,975	$0	$0	$155,975	$331,969	$0	$0
XIII. PROMOTION AND ADVERTISING	$90,314	$85,082	$81,078	$82,894	$339,368	$137,146	$40,235	$82,911	$14,000	$63,629	$66,016	$72,577
XIV. COMMUNICATION AND EDUCATION	$114,164	$102,777	$105,814	$106,248	$429,003	$218,035	$40,022	$134,912	$43,101	$81,121	$70,910	$48,936
XV. RESEARCH, MONITORING AND EVALUATION	$36,870	$43,029	$116,898	$30,074	$226,871	$133,631	$39,000	$79,376	$15,255	$22,088	$71,152	$0
XVI. PROGRAM RELATED TRAINING/CONF./MTGS.	$69,129	$108,858	$85,616	$99,455	$383,058	$281,837	$112,810	$66,697	$102,330	$63,240	$37,982	$0
XVII. OTHER DIRECT COSTS	$204,000	$214,200	$224,910	$236,157	$879,267	$703,414	$527,560	$87,927	$87,927	$87,927	$87,927	$0
SUBTOTAL ALL DIRECT COSTS	$2,173,689	$2,314,532	$2,413,402	$2,342,052	$9,243,675	$6,167,549	$3,884,032	$1,122,785	$1,160,731	$1,641,039	$945,562	$489,522
XV. INDIRECT COSTS/OVERHEADS	$175,788	$177,285	$186,151	$195,457	$734,678	$587,741	$440,806	$73,467	$73,467	$73,467	$73,467	$0
GRAND TOTAL	**$2,349,475**	**$2,491,816**	**$2,599,553**	**$2,537,509**	**$9,978,354**	**$6,755,290**	**$4,324,839**	**$1,196,252**	**$1,234,199**	**$1,714,506**	**$1,019,029**	**$489,522**
Proportion of total budget						67.70%	43%	12%	12%	17%	10%	5%

2.2